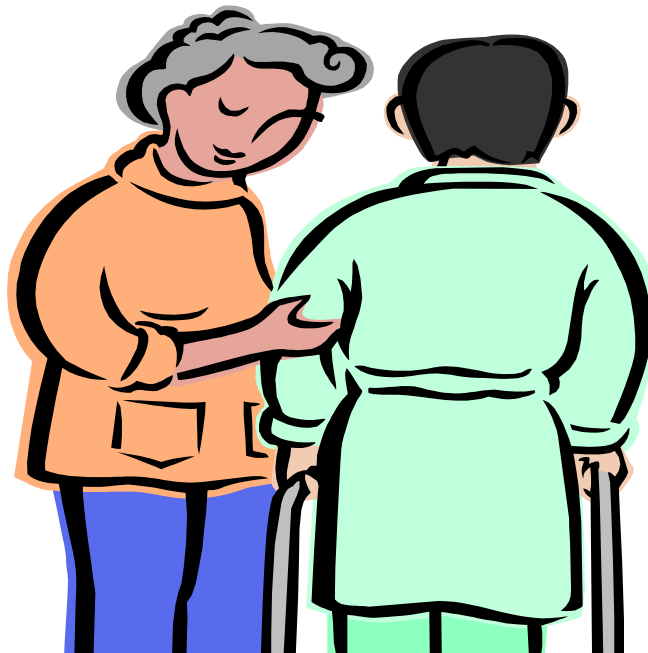


# **ASSISTED LIVING FACILITY ASSESSMENT MANUAL**



**Commonwealth of Virginia  
Department of Social Services  
Division of Family Services, Adult Services Program  
7 North Eighth Street  
Richmond, Virginia 23219**

**October 2007**

## ***A NOTE ABOUT THIS REVISION***

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This manual was prepared in cooperation with staff of the Virginia Departments of Medical Assistance Services (DMAS), Social Services, Aging, Health, Rehabilitative Services, Mental Health, Mental Retardation and Substance Abuse Services, and Corrections as well as public human services agency assessors and other interested parties.

This version replaces the working draft that was issued in November 2002.

The major changes in this manual are:

- Inclusion of information from the July 2005 update of the User's Manual: Virginia Uniform Assessment Instrument, particularly with regard to Appendix K on Indicators for Referral to the Department of Mental Health, Mental Retardation, and Substance Abuse Services. Appendix K was developed by an interagency collaborative group sponsored by the Office of the Secretary of Health and Human Resources.
- The manual chapters have been reordered to more closely follow the case management process.
- A new chapter was added to address the Division of Licensing Programs emphasis on appropriate assessment and placement in Assisted Living Facilities of individuals who may exhibit indicators of mental illness, mental retardation and substance abuse.
- A new chapter was added to address the Alzheimer's Assisted Living Waiver available in approved Assisted Living Facilities.
- Addition of the Department of Corrections as a public human agency assessor for assisted living facility assessments for inmates leaving the correctional system and who are in need of assisted living facility care.
- Inclusion of updated language from recent amendments to the Code of Virginia, Title 63.2, for both the Adult Services Program and the Division of Licensing Programs.

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## CHAPTER I: GENERAL INFORMATION

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## 1. PURPOSE OF THIS MANUAL

This manual provides guidance related to the assessment process for assisted living facilities (ALFs) and Medicaid-funded targeted ALF case management. The focus of this manual is ALF residents and applicants who are eligible for or receiving an Auxiliary Grant (AG).

Please note that this manual should be used in conjunction with the *User's Manual: Virginia Uniform Assessment Instrument*, revised July 2005. The Virginia Uniform Assessment Instrument (UAI) is used by all public human services agencies in Virginia for long-term care services and not just for ALF assessments and nursing facility preadmission screenings. This manual focuses on the process for using the UAI for assessments of individuals who are applicants to or residents of an ALF.

DMAS will not reimburse for assessments of private pay individuals. For information on the assessment of private pay ALF residents, refer to the *User's Manual: Virginia Uniform Assessment Instrument (UAI) for Private Pay Residents of Assisted Living Facilities* which is available from the VDSS Adult Services Program web site: [http://www.dss.virginia.gov/family/as/uai\\_manual.cgi](http://www.dss.virginia.gov/family/as/uai_manual.cgi) or the local agency web site.

## 2. BACKGROUND

Since July 1, 1994, publicly funded human service agencies in Virginia, including the local departments of social services, area agencies on aging, centers for independent living, state facility staff of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), and Medicaid preadmission screening (PAS) teams have been using one common assessment, the Uniform Assessment Instrument (UAI), to gather information for the determination of an individual's care needs, for service eligibility, and for planning and monitoring client care needs across agencies and services. The UAI is comprised of a short assessment, designed to be an intake/screening document and a full assessment, designed to be a comprehensive evaluation. The completion of the short UAI (Part A) or full UAI (Part A and Part B) is based on the initial review of the individual's needs and which long-term care service has been requested. See Exhibit 1 in this chapter for the text of the UAI regulation.

Effective February 1, 1996, all assisted living facility (ALF) applicants, prior to admission, and residents of ALFs must be assessed, at least annually, using the UAI to determine the need for residential or assisted living care, regardless of payment source or length of stay. In addition, all ALF residents must be assessed using the UAI whenever there is a significant change in the resident's condition that may warrant a change in level of care. Under Medicaid-funded targeted ALF case management services, Auxiliary Grant (AG) residents will receive an annual reassessment only and may receive ongoing targeted case management services when appropriate. Ongoing Medicaid-funded ALF targeted case management services are provided by a case manager to AG residents who have multiple needs

across multiple providers when the ALF cannot provide the services but they are available in the community. See Chapter VI for additional information on ongoing, targeted case management services.

DMAS will pay the ALF for services rendered while the individual is determined to be eligible for benefits under the AG program and authorized for assisted living. The assisted living authorization is considered effective as of the date the Medicaid Funded Long-Term Care Services Authorization (DMAS-96) is signed and dated.

### **3. AUXILIARY GRANT PROGRAM**

The Auxiliary Grant (AG) Program is a state and locally funded assistance program to supplement the income of a recipient of Supplemental Security Income (SSI) and certain other aged, blind, or disabled individuals residing in a licensed ALF. This is assistance available from local departments of social services to ensure that recipients are able to maintain a standard of living that meets a basic level of need. Before an individual can receive assistance from the AG program, the local department of social services must determine eligibility for the program where the individual has residence. Residence for AG eligibility is determined by the city or county within the state where the person last lived outside of an institution or adult foster care home. Any records/statements can be used to determine place of residence. If residency cannot be determined, residency is where the individual is living at the time of application. If the individual is entering the ALF from a state institution, the application is to be filed in the locality where the individual resided before he or she entered the state institution.

Entitlement to assistance for an individual meeting all eligibility criteria begins the month the application for the AG program is received by a local department of social services. If an individual does not meet all eligibility criteria at the time of application, but meets all criteria when the application is processed, entitlement begins the month all criteria are met.

All applicants for an AG must have an assessment completed before AG payment can begin. Verification of the initial assessment will be a completed DMAS-96, Medicaid Funded Long-Term Care Services Authorization (see Chapter II), sent to the appropriate local department of social services eligibility worker by the assessor. At the time of the resident's annual reassessment, the assessor completes the ALF Eligibility Communication Document (Appendix C). This form tells the eligibility worker that the resident continues to meet the criteria for continued ALF placement so that AG eligibility can be redetermined.

An individual's Medicaid number may usually be used to determine which local department of social services is responsible for determining an individual's eligibility for an AG. Prior to determining AG eligibility, the eligibility worker must verify the agency which determined Medicaid eligibility through VAMMIS. The first three

numbers of the Medicaid number usually correspond to the city/county code (FIPS code) of the local department of social services that is responsible for the payment of the AG. The FIPS codes are found in Exhibit 2 of this chapter. The assessor is advised to use any other documentation that may be available to assist in determining the appropriate local department of social services.

To be eligible for an AG in Virginia, an individual must meet all of the following:

- Be 65 or over or be blind or be disabled.
- Reside in a licensed ALF or adult foster care home.
- Be a citizen of the United States or an alien who meets specified criteria.
- Have a non-exempted (countable) income less than the total of the AG rate approved for the ALF plus the personal needs allowance.
- Have non-exempted resources less than \$2,000 for one person or \$3,000 for a couple.
- Have been assessed and determined to be in need of care in an ALF or adult foster care home.

The Auxiliary Grant provides for the following services:

### **3.1 Room and Board**

- Provision of a furnished room in a facility that meets applicable building and fire safety codes.
- Housekeeping services based on the needs of the resident.
- Meals and snacks, including extra portions and special diets.
- Clean bed linens and towels as needed and at least once a week.

### **3.2 Maintenance and Care**

- Medication administration, including insulin injections.
- Provision of generic personal toiletries including soap and toilet paper.
- Minimal assistance with personal hygiene including bathing, dressing, oral hygiene, hair grooming and shampooing, care of clothing, shaving, care of toenails and fingernails, arranging for haircuts as needed, care of needs associated with menstruation or occasional bladder or bowel incontinence.
- Minimal assistance with care of personal possessions; care of personal funds if requested by the recipient and residence policy allows it; use of telephone; arranging transportation; obtaining necessary personal items and clothing; making and keeping appointments; correspondence; securing health care and transportation when needed for medical treatment; providing social and recreational activities as required by licensing regulations; and general supervision for safety.

#### **4. DESCRIPTION OF AN ASSISTED LIVING FACILITY**

Assisted living facilities (ALFs) are licensed by the Virginia Department of Social Services (VDSS), Division of Licensing Programs, to provide maintenance or care to four or more adults. ALF placement is appropriate when the adult is assessed to need assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), administration of medication and/or supervision due to behavioral problems, but does not require the level of care provided in a nursing facility. A searchable data base of licensed ALFs can be found at: <http://www.dss.virginia.gov/facility/search/alf.cgi>.

A list of the VDSS licensing offices and the counties and cities they serve can be found at: <http://www.dss.virginia.gov/division/license/district.html>

ALFs are licensed to provide 1) residential living only or 2) residential living and assisted living level of care. DMAS provides additional reimbursement for assisted living. ALFs must be licensed by VDSS for assisted living before they can enroll with DMAS as an assisted living provider. Payment for assisted living services is effective from the date of authorization on the Medicaid Funded Long-Term Care Services Authorization (DMAS-96).

Once an ALF has been licensed by VDSS for assisted living, the ALF can enroll as a Medicaid provider to receive payment for assisted living services on behalf of its AG residents. Initially, the ALF will submit an admission package (as described in Chapter VII) to receive approval to bill for assisted living services. DMAS will reimburse \$3 per day not to exceed \$90 a month for assisted living services. Payment will be made directly to assisted living facilities through the submission of a CMS-1500 invoice to DMAS. These payments are an add-on payment to the base AG payment that the ALF receives directly from the resident. Please note that AG payments are made by VDSS directly to the resident, not the ALF.

#### **5. A NOTE ON INTENSIVE ASSISTED LIVING CARE**

Prior to March 17, 2000, there were two levels of assisted living care for payment purposes in ALFs (regular assisted living and intensive assisted living), which were available to individuals who require assistance in activities of daily living and instrumental activities of daily living, which are above the room, board, and supervision provided by the ALF and as reimbursed by the AG program. In March 2000, the Health Care Financing Administration (now the Centers for Medicare and Medicaid) did not renew Virginia's Intensive Assisted Living Waiver. On and after March 17, 2000, the IAL Waiver is no longer available as a Medicaid-funded alternative to nursing facility placement for new applicants. There are now only two levels of care: residential care and assisted living. Please see Chapter IX for information on the Intensive Assisted Living Program.

## **6. DEFINITION OF ASSESSMENT**

The ALF assessment using the Virginia Uniform Assessment Instrument (UAI) is a standardized approach using common definitions to gather sufficient information on applicants to and residents of ALFs to determine their care needs, and, for AG recipients, to determine their need for residential care. The assessment is the authorizing mechanism for public reimbursement for ALF services.

### **6.1 Assessment of ALF applicants and residents is a process to:**

- Evaluate the medical, nursing, developmental, psychological, and social needs of each individual seeking ALF admission and continued placement;
- Analyze what specific services the individual needs; and
- Determine the level of care required by the individual by applying the criteria for ALF care. (See Appendix B for ALF level of care criteria.)

### **6.2 The assessment of the availability of ALF services depends upon:**

- Whether an ALF, licensed to provide the level of care to meet the needs of the individual, exists in the community;
- Whether financial eligibility can be established; and
- Whether the ALF states/demonstrates that it can meet the individual's needs.

## **7. THE VIRGINIA UNIFORM ASSESSMENT INSTRUMENT (UAI)**

The Virginia Uniform Assessment Instrument (UAI) is required to be used by all public human services agencies that provide long-term care services. The UAI provides the framework for determining an individual's care needs. It contains measurable and common definitions for rating how individuals function in daily life activities. For public pay residents, only the short assessment (first four pages) of the UAI is required plus an assessment of behavior/orientation and medication administration. A one page "Attachment to a Public Pay Short Form Assessment" is available to document these assessment factors not covered on the first four pages of the UAI (See APPENDIX C). If, upon completion, it is determined that the individual is dependent in two or more activities of daily living or dependent in behavior, then the full assessment (12 pages of the UAI) must be completed.

## **8. RESPONSIBILITIES OF DMAS, ASSESSORS, AND ALF STAFF**

### **8.1 Department of Medical Assistance Services Responsibilities**

The responsibilities of the Department of Medical Assistance Services are:

- Payment for assessments and targeted case management.
- Reimbursement to ALF providers for the add-on payment for assisted living.
- Enrollment of providers (assessors and ALFs).
- Conducting quality management reviews of assisted living services to assure that authorized services were appropriately delivered.

## **8.2 Assessor Responsibilities**

**Any public human services agency assessor who completes an initial assessment for an individual is responsible for the following:**

- Determining if the individual to be assessed is already receiving an AG or has made application for the AG.
- Completing the assessment process within two weeks of the referral.
- Determining appropriate level of care and authorizing services.
- Contacting the ALF of choice and determining if the ALF is licensed for the individual's level of care authorization and if the ALF can meet the individual's needs.
- Directly assisting the individual through the admission process if requested.
- Submitting all paperwork to all entities as directed.
- Referring the individual for a psychiatric or psychological evaluation if needed. (see Appendix K of the User's Manual: Virginia Uniform Assessment Instrument, for more information on when these evaluations are recommended).
- Planning for the required annual reassessment; making referrals to an alternate assessor, if needed.

## **8.3 Additional Responsibilities of the Department of Social Services**

In addition to the above responsibilities of agency assessors, the responsibilities of the Department of Social Services in the assessment of ALF residents include:

- Ensuring that all residents are assessed as required.
- Monitoring compliance with Division of Licensing Programs' standards.
- Performing the licensing of ALFs.

## 8.4 ALF Staff Responsibilities

The ALF staff is responsible for ensuring that an assessment is conducted prior to the individual's admission to determine if he or she meets ALF criteria and whether the facility can meet the identified needs of the individual. ALF staff must coordinate with the assessor to ensure that assessments are completed as required. Except in the event of a documented emergency (see Chapter V), all individuals must be assessed to determine necessity for ALF placement **prior to** the placement. ALF staff must keep all assessments and related documentation in the resident's record. ALF staff must comply with the standards and regulations of the VDSS Division of Licensing Programs as well as with all standards and regulations of DMAS if the facility chooses to participate and receive Medicaid reimbursement for assisted living services.

ALF staff must know the criteria for the levels of care in an ALF and are responsible for arranging for the discharge of the resident whenever a resident does not meet, either upon admission or at any later time, the criteria for level of care for which the ALF is licensed. Discharge is the process that ends the stay in an ALF. ALF staff must assist with the planning for post-discharge services when the resident is returned to a home-based placement, a nursing facility, another ALF, or facility operated by DMHMRSAS. ALF staff must provide written notification to the LDSS financial eligibility worker in the jurisdiction responsible for authorizing the AG and the resident's case manager/assessor of the date of discharge. The current UAI should follow the resident.

The written notification to the LDSS for a scheduled discharge must be provided at least 14 days prior to the discharge date. In the event of an emergency discharge, the notification shall be made as rapidly as possible but must be made by the close of business on the day following the emergency discharge. In the event of the death of the resident, the notification must be made within 5 days after the date of the death.

The VDSS Division of Licensing Programs requires that individuals have a physical examination within 30 days prior to admission to the ALF. The ALF staff is responsible for ensuring that the required elements of the examination have been documented as completed. The applicant's social worker or case manager may need to assist the applicant in obtaining the physical examination in order to complete the admission process. The Division of Licensing Programs has made available a model form for the physical examination. Other forms may be used if they contain the same information as the model form. The form, "Report of Resident Physical Examination" can be found at: [http://www.dss.virginia.gov/facility/alf\\_forms.cgi](http://www.dss.virginia.gov/facility/alf_forms.cgi).

## **9. COORDINATION OF ASSESSMENTS**

Any qualified assessor is authorized to perform initial ALF assessments. All assessors within a locality should coordinate assessment and reassessment responsibilities for the locality so that the assessment and reassessment burden does not fall solely on one agency. When there is no other qualified assessor willing or able, the local departments of social services must provide the service.

If an individual have been assessed with the UAI by any public human services agency and the assessment is less than 12 months old, it is not necessary to complete a new UAI. Instead, the assessor assisting with the placement should:

- review and update the current UAI as needed by striking through and updating the appropriate elements;
- complete the Medicaid authorization process (see Chapter II); and
- send to all necessary parties for notification and payment (also Chapter II).

For new admissions, previously completed UAIs are acceptable if completed within 90 days prior to admission, and there has been no significant change in the applicant's physical and/or functional condition.

An ALF-to-ALF transfer would not require a new assessment unless there is a change in level of care. In routine transfers from one ALF to another where there is no change in level of care, the sending and receiving ALFs must ensure that all requirements are followed. The current UAI should follow the resident.

State regulation (22 VAC 40-745-10 et seq.) authorizes public human service agencies and other qualified assessors to complete assessments for AG recipients and applicants needing ALF placement. Assessors may be reimbursed for assessments provided that they have a contract for those activities with DMAS. Certain providers may be more appropriate to complete assessments than others. For example, regulations require that clients of a community service board ((BHA)) or behavioral health authority will be assessed and reassessed by qualified assessors employed by the community services board.

### **9.1 Differences between PAS (Preadmission Screening) and ALF Assessments**

#### **PAS**

- Assessors limited to LDSS and local health departments or hospital providers.
- Team concept with physician signature required.

- Social worker and registered nurse complete the assessment.
- UAI, DMAS-96, DMAS-97, and Level II screening for conditions of mental illness and/or mental retardation required.
- Reimbursement is split among community-based screeners.

### **ALF Assessments**

- Expands providers to other public agencies and physicians.
- No team required; the individual assessor may seek professional assistance as needed.
- No physician signature required.
- Assessor must have the knowledge, skills, and abilities of a case manager.
- Forms required are the UAI and DMAS-96.
- There is no reimbursement split.

For information regarding the completion of Pre-Admission Screenings, please access the DMAS website at: [www.dmas.virginia.gov](http://www.dmas.virginia.gov)

The Pre-Admission Screening manual, which contains information regarding ALF assessments, can be found under the Provider Manual Section of the website.

For information regarding Frequently Asked Questions related to Pre-Admission Screening or to submit a question, please use the following website:  
[http://www.dmas.virginia.gov/ltc-pre\\_admin\\_screener.htm](http://www.dmas.virginia.gov/ltc-pre_admin_screener.htm).

## **10. SUBCONTRACTORS**

If a subcontractor is used by an authorized agency to complete assessments, the contracting agency is responsible to monitor the subcontractor's performance. The DMAS provider agreement states that, "The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider." The contracting agency will be responsible for the quality, accuracy, and timeliness of any assessment completed by a subcontractor. In the case of a subcontractor, the authorized assessment agency requests the reimbursement for the assessment from DMAS. DMAS reimburses the authorized assessment agency that, in turn, reimburses the subcontractor.

## **11. ALFs OPERATED BY A COMMUNITY SERVICES BOARD**

Some CSBs/BHAs operate an ALF. In this case, the CSB/BHA employee can complete the UAI for residents of the agency-operated ALF. In order to be reimbursed for a public pay assessment, the assessor may be an employee of the CSB/BHA, but not of the ALF. The distinction is whether the staff is considered direct service staff. Direct service staff or employees of the ALF cannot perform either assessment or targeted ALF case management services to the residents. If

the ALF staff is also the resident's case manager, case management will be a part of the staff's usual responsibilities and will not be reimbursed separately by DMAS. If an agency staff person is placed in a facility to facilitate case management activities, such staff could complete the assessment and perform targeted case management services and be reimbursed by DMAS for these activities.

## **12. FREEDOM OF CHOICE**

For public pay individuals, the assessor or case manager must offer the individual the choice of service provider(s), including case managers and ALFs. When ongoing Medicaid-funded targeted ALF case management is needed, these choices must be documented on the Plan of Care (see Appendix C). The individual's choice of providers is a federal, as well as professional and ethical, requirement.

## **13. RECORDS RETENTION AND DOCUMENTATION REQUIREMENTS**

All assessment forms and Medicaid authorization forms (e.g., the DMAS-96) must be retained for a period of not less than five years from the date of the assessment and/or implementation of case management services. Assessments and related documentation must be legible and maintained in accordance with accepted professional standards and practices. All records, including the UAI as well as any computerized records and forms, must be completely signed with name and professional title of author and completely dated with month, day, and year.

## **14. CASE MANAGEMENT**

Case management is a system under which the responsibility for locating, coordinating, and monitoring services rests with a designated person or organization. Medicaid-funded ALF case management includes the annual reassessment only or ongoing targeted case management. It is believed that most AG residents of ALFs will only need the required annual reassessment and not ongoing targeted case management services. See Chapter V for additional information on Medicaid-funded ALF targeted case management services.

**EXHIBIT 1. SELECTIONS FROM THE *CODE OF VIRGINIA* RELATING TO THE  
UNIFORM ASSESSMENT INSTRUMENT**

**§ 63.2-1804. Uniform assessment instrument.**

A uniform assessment instrument setting forth a resident's care needs shall be completed for all residents upon admission and at subsequent intervals as determined by Board regulation. No uniform assessment instrument shall be required to be completed upon admission if a uniform assessment instrument was completed by a case manager or other qualified assessor within ninety days prior to such admission to the assisted living facility unless there has been a change in the resident's condition within that time which would affect the admission. Uniform assessment instruments shall not be required to be completed more often than once every twelve months on individuals residing in assisted living facilities except that uniform assessment instruments shall be completed whenever there is a change in the resident's condition that appears to warrant a change in the resident's approved level of care. At the request of the assisted living facility, the resident's representative, the resident's physician, the Department or the local department, an independent assessment, using the uniform assessment instrument shall be completed to determine whether the resident's care needs are being met in the current placement. The resident's case manager or other qualified assessor shall complete the uniform assessment instrument for public pay residents or, upon request by the private pay resident, for private pay residents. Unless a private pay resident requests the uniform assessment instrument be completed by a case manager or other qualified assessor, qualified staff of the assisted living facility or an independent private physician may complete the uniform assessment instrument for private pay residents; however, for private pay residents, social and financial information which is not relevant because of the resident's payment status shall not be required. The cost of administering the uniform assessment instrument pursuant to this section shall be borne by the entity designated pursuant to Board regulations. Upon receiving the uniform assessment instrument prior to admission of a resident, the assisted living facility administrator shall provide written assurance that the facility has the appropriate license to meet the care needs of the resident at the time of admission.

**§ 63.2-800. Auxiliary grants program; administration of program.**

D. In order to receive an auxiliary grant while residing in an assisted living facility, an individual shall have been evaluated by a case manager or other qualified assessor to determine his need for residential living care. An individual may be admitted to an assisted living facility pending evaluation and assessment as allowed by Board regulations, but in no event shall any public agency incur a financial obligation if the individual is determined ineligible for an auxiliary grant. For purposes of this section, "case manager" means an employee of a human services agency who is qualified and designated to develop and coordinate plans of care. The Board shall adopt regulations to implement the provisions of this subsection.

## EXHIBIT 2. CITY/COUNTY (FIPS) CODES

### **Counties**

001 Accomack  
003 Albemarle  
005 Alleghany  
007 Amelia  
009 Amherst  
011 Appomattox  
013 Arlington  
015 Augusta  
017 Bath  
019 Bedford  
021 Bland  
023 Botetourt  
025 Brunswick  
027 Buchanan  
029 Buckingham  
031 Campbell  
033 Caroline  
036 Charles City  
037 Charlotte  
041 Chesterfield  
043 Clarke  
045 Craig  
047 Culpeper  
049 Cumberland  
051 Dickenson  
053 Dinwiddie  
057 Essex  
059 Fairfax  
061 Fauquier  
063 Floyd  
065 Fluvanna  
067 Franklin  
069 Frederick  
071 Giles  
073 Gloucester  
075 Goochland  
077 Grayson  
079 Greene  
081 Greensville  
083 Halifax  
085 Hanover  
087 Henrico  
089 Henry  
091 Highland  
093 Isle of Wight  
095 James City  
097 King & Queen  
099 King George  
101 King William  
103 Lancaster

105 Lee  
107 Loudoun  
109 Louisa  
111 Lunenburg  
113 Madison  
115 Mathews  
117 Mecklenburg  
119 Middlesex  
121 Montgomery  
125 Nelson  
127 New Kent  
131 Northampton  
133 Northumberland  
135 Nottoway  
137 Orange  
139 Page  
141 Patrick  
143 Pittsylvania  
145 Powhatan  
147 Prince Edward  
149 Prince George  
153 Prince William  
157 Rappahannock  
159 Richmond County  
161 Roanoke County  
163 Rockbridge  
165 Rockingham  
167 Russell  
169 Scott  
171 Shenandoah  
173 Smyth  
175 Southampton  
177 Spotsylvania  
179 Stafford  
181 Surry  
183 Sussex  
185 Tazewell  
187 Warren  
191 Washington  
193 Westmoreland  
195 Wise  
197 Wythe  
199 York

### **Cities**

510 Alexandria  
515 Bedford  
520 Bristol  
530 Buena Vista  
540 Charlottesville  
550 Chesapeake  
560 Clifton Forge  
570 Colonial Heights  
580 Covington  
590 Danville  
595 Emporia  
600 Fairfax City  
610 Falls Church  
620 Franklin  
630 Fredericksburg  
640 Galax  
650 Hampton  
660 Harrisonburg  
670 Hopewell  
678 Lexington  
680 Lynchburg  
683 Manassas  
685 Manassas Park  
690 Martinsville  
700 Newport News  
710 Norfolk  
720 Norton  
730 Petersburg  
740 Portsmouth  
750 Radford  
760 Richmond City  
770 Roanoke City  
780 South Boston  
790 Staunton  
800 Suffolk  
810 Virginia Beach  
820 Waynesboro  
830 Williamsburg  
840 Winchester

## CHAPTER II: ASSISTED LIVING FACILITY ASSESSMENT AND AUTHORIZATION

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## 1. LEGAL BASE

Effective February 1, 1996, the Code of Virginia, § 63.2-1804, *Uniform Assessment Instrument*, and State Board regulations, 22 VAC 40-745 et seq. effect February 1, 1996, have required that all ALF applicants, prior to admission, and residents of ALFs must be assessed, at least annually, using the UAI to determine the need for residential or assisted living care, regardless of payment source or length of stay. Throughout this manual, text that appears in capital letters denotes material from the Department of Social Services regulations, 22 VAC 40-745-10 et seq. The full text of these regulations is available at: <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+22VAC40-745>.

The Department of Medical Assistance Services (DMAS) is responsible for those aspects of the legislation, regulation, and policy related to the payment of assessments, targeted case management, and assisted living level of care for AG residents of ALFs.

## 2. DEFINITIONS

THE FOLLOWING WORDS AND TERMS, WHEN USED IN THIS CHAPTER, SHALL HAVE THE FOLLOWING MEANINGS, UNLESS THE CONTEXT CLEARLY INDICATES OTHERWISE:

**2.1 "ACTIVITIES OF DAILY LIVING (ADLS)"** MEANS BATHING, DRESSING, TOILETING, TRANSFERRING, BOWEL CONTROL, BLADDER CONTROL, AND EATING/FEEDING. A PERSON'S DEGREE OF INDEPENDENCE IN PERFORMING THESE ACTIVITIES IS A PART OF DETERMINING APPROPRIATE LEVEL OF CARE AND SERVICES.

**2.2 "APPLICANT"** MEANS AN ADULT PLANNING TO RESIDE IN AN ASSISTED LIVING FACILITY.

**2.3 "ASSESSMENT"** MEANS A STANDARDIZED APPROACH USING COMMON DEFINITIONS TO GATHER SUFFICIENT INFORMATION ABOUT APPLICANTS TO AND RESIDENTS OF ASSISTED LIVING FACILITIES TO DETERMINE THE NEED FOR APPROPRIATE LEVEL OF CARE AND SERVICES.

**2.4 "ASSISTED LIVING CARE"** MEANS A LEVEL OF SERVICE PROVIDED BY AN ASSISTED LIVING FACILITY FOR ADULTS WHO MAY HAVE PHYSICAL OR MENTAL IMPAIRMENTS AND REQUIRE AT LEAST MODERATE ASSISTANCE WITH THE ACTIVITIES OF DAILY LIVING. MODERATE ASSISTANCE MEANS DEPENDENCY IN TWO OR MORE OF THE ACTIVITIES OF DAILY LIVING. INCLUDED IN THIS LEVEL OF SERVICE ARE INDIVIDUALS WHO ARE DEPENDENT IN BEHAVIOR PATTERN (I.E., ABUSIVE, AGGRESSIVE, DISRUPTIVE).

**2.5 "ASSISTED LIVING FACILITY (ALF)"** MEANS ANY PUBLIC OR PRIVATE ASSISTED LIVING FACILITY THAT IS REQUIRED TO BE LICENSED AS AN ASSISTED LIVING FACILITY BY THE DEPARTMENT OF SOCIAL SERVICES UNDER CHAPTER 17 (§ 63.2-1700 ET SEQ.) OF TITLE 63.2 OF THE CODE OF VIRGINIA, SPECIFICALLY, ANY CONGREGATE RESIDENTIAL SETTING THAT PROVIDES OR COORDINATES PERSONAL AND HEALTH CARE SERVICES, 24-HOUR SUPERVISION, AND ASSISTANCE (SCHEDULED AND UNSCHEDULED) FOR THE MAINTENANCE OR CARE OF FOUR OR MORE ADULTS WHO ARE AGED, INFIRM OR DISABLED AND WHO ARE CARED FOR IN A PRIMARILY RESIDENTIAL SETTING, EXCEPT (I) A FACILITY OR PORTION OF A FACILITY LICENSED BY THE STATE BOARD OF HEALTH OR THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES, BUT INCLUDING ANY PORTION OF SUCH FACILITY NOT SO LICENSED; (II) THE HOME OR RESIDENCE OF AN INDIVIDUAL WHO CARES FOR OR MAINTAINS ONLY PERSONS RELATED TO HIM BY BLOOD OR MARRIAGE; (III) A FACILITY OR PORTION OF A FACILITY SERVING INFIRM OR DISABLED PERSONS BETWEEN THE AGES OF 18 AND 21, OR 22 IF ENROLLED IN AN EDUCATIONAL PROGRAM FOR THE HANDICAPPED PURSUANT TO § 22.1-214 OF THE CODE OF VIRGINIA, WHEN SUCH FACILITY IS LICENSED BY THE DEPARTMENT AS A CHILDREN'S RESIDENTIAL FACILITY UNDER CHAPTER 17 (§ 63.2-1700 ET SEQ.) OF TITLE 63.2 OF THE CODE OF VIRGINIA, BUT INCLUDING ANY PORTION OF THE FACILITY NOT SO LICENSED; AND (IV) ANY HOUSING PROJECT FOR PERSONS 62 YEARS OF AGE OR OLDER OR THE DISABLED THAT PROVIDES NO MORE THAN BASIC COORDINATION OF CARE SERVICES AND IS FUNDED BY THE U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT, BY THE U.S. DEPARTMENT OF AGRICULTURE, OR BY THE VIRGINIA HOUSING DEVELOPMENT AUTHORITY. INCLUDED IN THIS DEFINITION ARE ANY TWO OR MORE PLACES, ESTABLISHMENTS OR INSTITUTIONS OWNED OR OPERATED BY A SINGLE ENTITY AND PROVIDING MAINTENANCE OR CARE TO A COMBINED TOTAL OF FOUR OR MORE AGED, INFIRM OR DISABLED ADULTS. MAINTENANCE OR CARE MEANS THE PROTECTION, GENERAL SUPERVISION AND OVERSIGHT OF THE PHYSICAL AND MENTAL WELL-BEING OF AN AGED, INFIRM OR DISABLED INDIVIDUAL.

**2.6 "ASSISTED LIVING FACILITY ADMINISTRATOR"** MEANS ANY INDIVIDUAL CHARGED WITH THE GENERAL ADMINISTRATION OF AN ASSISTED LIVING FACILITY, REGARDLESS OF WHETHER HE HAS AN OWNERSHIP INTEREST IN THE FACILITY AND MEETS THE REQUIREMENTS OF 22 VAC 40-71.

**2.7 "AUXILIARY GRANTS PROGRAM"** MEANS A STATE AND LOCALLY FUNDED ASSISTANCE PROGRAM TO SUPPLEMENT INCOME OF A SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENT OR ADULT WHO WOULD BE ELIGIBLE FOR SSI EXCEPT FOR EXCESS INCOME, WHO RESIDES IN AN ASSISTED LIVING FACILITY WITH AN APPROVED RATE.

- 2.8 "CASE MANAGEMENT"** MEANS MULTIPLE FUNCTIONS DESIGNED TO LINK INDIVIDUALS TO APPROPRIATE SERVICES. CASE MANAGEMENT MAY INCLUDE A VARIETY OF COMMON COMPONENTS SUCH AS INITIAL SCREENING OF NEED, COMPREHENSIVE ASSESSMENT OF NEEDS, DEVELOPMENT AND IMPLEMENTATION OF A PLAN OF CARE, SERVICE MONITORING, AND FOLLOW-UP.
- 2.9 "CASE MANAGEMENT AGENCY"** MEANS A PUBLIC HUMAN SERVICE AGENCY WHICH EMPLOYS OR CONTRACTS FOR CASE MANAGEMENT.
- 2.10 "CASE MANAGER"** MEANS AN EMPLOYEE OF A PUBLIC HUMAN SERVICES AGENCY WHO IS QUALIFIED AND DESIGNATED TO DEVELOP AND COORDINATE PLANS OF CARE.
- 2.11 "CONSULTATION"** MEANS THE PROCESS OF SEEKING AND RECEIVING INFORMATION AND GUIDANCE FROM APPROPRIATE HUMAN SERVICES AGENCIES AND OTHER PROFESSIONALS WHEN ASSESSMENT DATA INDICATE CERTAIN SOCIAL, PHYSICAL AND MENTAL HEALTH CONDITIONS.
- 2.12 "DEPARTMENT" OR "DSS"** MEANS THE VIRGINIA DEPARTMENT OF SOCIAL SERVICES.
- 2.13 "DEPENDENT"** MEANS, FOR ACTIVITIES OF DAILY LIVING (ADLS) AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS), THE INDIVIDUAL NEEDS THE ASSISTANCE OF ANOTHER PERSON OR NEEDS THE ASSISTANCE OF ANOTHER PERSON AND EQUIPMENT OR DEVICE TO SAFELY COMPLETE THE ACTIVITY. FOR MEDICATION ADMINISTRATION, DEPENDENT MEANS THE INDIVIDUAL NEEDS TO HAVE MEDICATIONS ADMINISTERED OR MONITORED BY ANOTHER PERSON OR PROFESSIONAL STAFF. FOR BEHAVIOR PATTERN, DEPENDENT MEANS THE PERSON'S BEHAVIOR IS AGGRESSIVE, ABUSIVE, OR DISRUPTIVE.
- 2.14 "DISCHARGE"** MEANS THE MOVEMENT OF A RESIDENT OUT OF THE ASSISTED LIVING FACILITY.
- 2.15 "EMERGENCY PLACEMENT"** MEANS THE TEMPORARY STATUS OF AN INDIVIDUAL IN AN ASSISTED LIVING FACILITY WHEN THE PERSON'S HEALTH AND SAFETY WOULD BE JEOPARDIZED BY NOT PERMITTING ENTRY INTO THE FACILITY UNTIL REQUIREMENTS FOR ADMISSION HAVE BEEN MET.
- 2.16 "FACILITY"** MEANS AN ASSISTED LIVING FACILITY.
- 2.17 "INDEPENDENT PHYSICIAN"** MEANS A PHYSICIAN WHO IS CHOSEN BY THE RESIDENT OF THE ASSISTED LIVING FACILITY AND WHO HAS NO FINANCIAL

INTEREST IN THE ASSISTED LIVING FACILITY, DIRECTLY OR INDIRECTLY, AS AN OWNER, OFFICER, OR EMPLOYEE OR AS AN INDEPENDENT CONTRACTOR WITH THE FACILITY.

**2.18 "INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)"** MEANS MEAL PREPARATION, HOUSEKEEPING, LAUNDRY, AND MONEY MANAGEMENT. A PERSON'S DEGREE OF INDEPENDENCE IN PERFORMING THESE ACTIVITIES IS A PART OF DETERMINING APPROPRIATE LEVEL OF CARE AND SERVICES.

**2.19 "MAXIMUM PHYSICAL ASSISTANCE"** MEANS THAT AN INDIVIDUAL HAS A RATING OF TOTAL DEPENDENCE IN FOUR OR MORE OF THE SEVEN ACTIVITIES OF DAILY LIVING AS DOCUMENTED ON THE UNIFORM ASSESSMENT INSTRUMENT.

**2.20 "MEDICATION ADMINISTRATION"** MEANS THE DEGREE OF ASSISTANCE REQUIRED TO TAKE MEDICATIONS AND IS A PART OF DETERMINING THE NEED FOR APPROPRIATE LEVEL OF CARE AND SERVICES.

**2.21 "PRIVATE PAY"** MEANS THAT A RESIDENT OF AN ASSISTED LIVING FACILITY IS NOT ELIGIBLE FOR BENEFITS UNDER THE AUXILIARY GRANTS PROGRAM.

**2.22 "PUBLIC HUMAN SERVICES AGENCY"** MEANS AN AGENCY ESTABLISHED OR AUTHORIZED BY THE GENERAL ASSEMBLY UNDER CHAPTERS 2 AND 3 (§§ 63.2-203 ET SEQ. AND 63.2-300 ET SEQ.) OF TITLE 63.2, CHAPTER 7 (§ 2.2-700 ET SEQ.) OF TITLE 2.2, CHAPTERS 1 AND 10 (§§ 37.1-1 ET SEQ. AND 37.1-194 ET SEQ.) OF TITLE 37.1, ARTICLE 5 (§ 32.1-30 ET SEQ.) OF CHAPTER 1 OF TITLE 32.1, CHAPTER 1 (§ 51.5-1 ET SEQ.) OF TITLE 51.5, OR §§ 53.1-21 AND 53.1-60 OF THE CODE OF VIRGINIA, OR HOSPITALS OPERATED BY THE STATE UNDER CHAPTERS 6.1 AND 9 (§§ 23-50.4 ET SEQ. AND 23-62 ET SEQ.) OF TITLE 23 OF THE CODE OF VIRGINIA AND SUPPORTED WHOLLY OR PRINCIPALLY BY PUBLIC FUNDS, INCLUDING BUT NOT LIMITED TO FUNDS PROVIDED EXPRESSLY FOR THE PURPOSES OF CASE MANAGEMENT.

**2.23 "PUBLIC PAY"** MEANS THAT A RESIDENT OF AN ASSISTED LIVING FACILITY IS ELIGIBLE FOR BENEFITS UNDER THE AUXILIARY GRANTS PROGRAM.

**2.24 "QUALIFIED ASSESSOR"** MEANS AN INDIVIDUAL WHO IS AUTHORIZED TO PERFORM AN ASSESSMENT, REASSESSMENT, OR CHANGE IN LEVEL OF CARE FOR AN APPLICANT TO OR RESIDENT OF AN ASSISTED LIVING FACILITY. FOR PUBLIC PAY INDIVIDUALS, A QUALIFIED ASSESSOR IS AN EMPLOYEE OF A PUBLIC HUMAN SERVICES AGENCY TRAINED IN THE COMPLETION OF THE UNIFORM ASSESSMENT INSTRUMENT. FOR PRIVATE PAY INDIVIDUALS, A QUALIFIED ASSESSOR IS STAFF OF THE ASSISTED

LIVING FACILITY TRAINED IN THE COMPLETION OF THE UNIFORM ASSESSMENT INSTRUMENT OR AN INDEPENDENT PRIVATE PHYSICIAN.

**2.25 "REASSESSMENT"** MEANS AN UPDATE OF INFORMATION AT ANY TIME AFTER THE INITIAL ASSESSMENT. IN ADDITION TO A PERIODIC REASSESSMENT, A REASSESSMENT SHOULD BE COMPLETED WHENEVER THERE IS A SIGNIFICANT CHANGE IN THE RESIDENT'S CONDITION.

**2.26 "RESIDENT"** MEANS AN INDIVIDUAL WHO RESIDES IN AN ASSISTED LIVING FACILITY.

**2.27 "RESIDENTIAL LIVING CARE"** MEANS A LEVEL OF SERVICE PROVIDED BY AN ASSISTED LIVING FACILITY FOR ADULTS WHO MAY HAVE PHYSICAL OR MENTAL IMPAIRMENTS AND REQUIRE ONLY MINIMAL ASSISTANCE WITH THE ACTIVITIES OF DAILY LIVING. MINIMAL ASSISTANCE MEANS DEPENDENCY IN ONLY ONE ACTIVITY OF DAILY LIVING OR DEPENDENCY IN ONE OR MORE OF THE SELECTED INSTRUMENTAL ACTIVITIES OF DAILY LIVING. INCLUDED IN THIS LEVEL OF SERVICE ARE INDIVIDUALS WHO ARE DEPENDENT IN MEDICATION ADMINISTRATION AS DOCUMENTED ON THE UNIFORM ASSESSMENT INSTRUMENT. THIS DEFINITION INCLUDES INDEPENDENT LIVING FACILITIES THAT VOLUNTARILY BECOME LICENSED.

**2.28 "SIGNIFICANT CHANGE"** MEANS A CHANGE IN A RESIDENT'S CONDITION THAT IS EXPECTED TO LAST LONGER THAN 30 DAYS. IT DOES NOT INCLUDE SHORT-TERM CHANGES THAT RESOLVE WITH OR WITHOUT INTERVENTION, A SHORT-TERM ACUTE ILLNESS OR EPISODIC EVENT, OR A WELL-ESTABLISHED, PREDICTIVE, CYCLIC PATTERN OF CLINICAL SIGNS AND SYMPTOMS ASSOCIATED WITH A PREVIOUSLY DIAGNOSED CONDITION WHERE AN APPROPRIATE COURSE OF TREATMENT IS IN PROGRESS.

**2.29 "TARGETED CASE MANAGEMENT"** MEANS THE PROVISION OF ONGOING CASE MANAGEMENT SERVICES BY AN EMPLOYEE OF A PUBLIC HUMAN SERVICES AGENCY CONTRACTING WITH THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES TO AN AUXILIARY GRANT RESIDENT OF AN ASSISTED LIVING FACILITY WHO MEETS THE CRITERIA SET FORTH IN PART IV (12 VAC 30-50-410 ET SEQ.) OF 12 VAC 30-50.

**2.30 "TOTAL DEPENDENCE"** MEANS THE INDIVIDUAL IS ENTIRELY UNABLE TO PARTICIPATE IN THE PERFORMANCE OF AN ACTIVITY OF DAILY LIVING.

**2.31 "UNIFORM ASSESSMENT INSTRUMENT"** MEANS THE DEPARTMENT-DESIGNATED ASSESSMENT FORM. THERE IS AN ALTERNATE VERSION OF THE UNIFORM ASSESSMENT INSTRUMENT WHICH MAY BE USED FOR PRIVATE PAY RESIDENTS; SOCIAL AND FINANCIAL INFORMATION WHICH IS

NOT RELEVANT BECAUSE OF THE RESIDENT'S PAYMENT STATUS IS NOT INCLUDED ON THIS VERSION.

**2.32 "USER'S MANUAL: VIRGINIA UNIFORM ASSESSMENT INSTRUMENT"** MEANS THE DEPARTMENT-DESIGNATED HANDBOOK CONTAINING COMMON DEFINITIONS AND PROCEDURES FOR COMPLETING THE DEPARTMENT-DESIGNATED ASSESSMENT FORM.

**2.33 "VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)"** MEANS THE SINGLE STATE AGENCY DESIGNATED TO ADMINISTER THE MEDICAL ASSISTANCE SERVICES PROGRAM IN VIRGINIA.

### **3. POPULATION TO BE ASSESSED**

ALL RESIDENTS OF AND APPLICANTS TO ASSISTED LIVING FACILITIES MUST BE ASSESSED FACE-TO-FACE USING THE UNIFORM ASSESSMENT INSTRUMENT PRIOR TO ADMISSION, AT LEAST ANNUALLY, AND WHENEVER THERE IS A SIGNIFICANT CHANGE IN THE RESIDENT'S CONDITION.

FOR PRIVATE PAY INDIVIDUALS, QUALIFIED STAFF OF THE ASSISTED LIVING FACILITY OR AN INDEPENDENT PRIVATE PHYSICIAN MAY COMPLETE THE UNIFORM ASSESSMENT INSTRUMENT. QUALIFIED STAFF OF THE ASSISTED LIVING FACILITY ARE EMPLOYEES OF THE FACILITY WHO HAVE SUCCESSFULLY COMPLETED STATE-APPROVED TRAINING ON THE UNIFORM ASSESSMENT INSTRUMENT FOR EITHER PUBLIC OR PRIVATE PAY ASSESSMENTS.

Except in the event of a documented emergency (see Chapter V), all individuals must be assessed to determine the necessity for ALF placement **prior to** the ALF placement. Please note that this manual describes procedures for the assessment of AG recipients and applicants. Public human services agency assessors are not required to assess private pay individuals, but may do so when requested. If they choose to assess private pay individuals, the public human services agency assessor may not charge more than the public pay reimbursement rates for conducting the assessment.

### **4. ASSESSORS FOR PUBLIC PAY INDIVIDUALS**

FOR PUBLIC PAY INDIVIDUALS, A UNIFORM ASSESSMENT INSTRUMENT SHALL BE COMPLETED BY A CASE MANAGER OR A QUALIFIED ASSESSOR TO DETERMINE THE NEED FOR RESIDENTIAL CARE OR ASSISTED LIVING CARE SERVICES. THE ASSESSOR IS QUALIFIED TO COMPLETE THE ASSESSMENT IF THE ASSESSOR HAS COMPLETED A STATE-APPROVED TRAINING COURSE ON THE STATE-DESIGNATED UNIFORM ASSESSMENT INSTRUMENT. PUBLIC HUMAN SERVICES AGENCY ASSESSORS WHO ROUTINELY COMPLETE, AS PART OF THEIR JOB DESCRIPTIONS, UNIFORM ASSESSMENT INSTRUMENTS FOR APPLICANTS TO OR RESIDENTS OF ASSISTED LIVING FACILITIES PRIOR TO JANUARY 1, 2004, MAY BE

## DEEMED TO BE QUALIFIED ASSESSORS WITHOUT THE COMPLETION OF THE TRAINING COURSE.

For public pay individuals, assessors include the following Virginia public agencies:

**4.1 Local departments of social services:** There are 120 local departments of social services (LDSS) across the state that serve as the service entry point for customers. Local agency financial eligibility staffs are responsible for determining eligibility for participation in assistance programs. Services staffs are authorized to make payments to customers and vendors for services and provide direct services and family-focused case management to customers. LDSS also participate on the Preadmission Screening (PAS) Team with local health departments and can authorize Medicaid-funded nursing facility or community-based care services.

**4.2 Area agencies on aging.** The mission of the area agencies on aging (AAAs) is to develop or enhance comprehensive and coordinated community-based systems of services for the elderly in their designated planning and service areas. Each AAA serves a specific geographic area known as the planning and service area (PSA). The 25 AAAs serve all jurisdictions in the state. AAAs provide services directly or through contracts with other community service providers.

**4.3 Centers for independent living.** Centers for independent living (CILs) are non-profit organizations which provide peer counseling, information and referral, independent living skills training, and advocacy to people with all types of disabilities. The Department of Rehabilitative Services at the Woodrow Wilson Rehabilitation Center operates another independent living program.

**4.4 Community services board / Behavioral health authority.** Community services boards (CSBs) and behavioral health authorities (BHAs) deliver mental health, mental retardation, and substance abuse services. CSBs/BHAs provide some services in all 136 cities and counties in Virginia. Boards and authorities function not only as service providers, but also as client advocates, community educators and organizers, program developers and planners, and advisors to their local governments, serving as the locus of fiscal and programmatic accountability.

**4.5 Local departments of health.** There are 201 local health departments, including every city and county in the Commonwealth. They are responsible for local health initiatives that vary according to the needs of the community. Each local health department belongs to a district health department. Local health departments also participate on the PAS Team with local departments of social services and can authorize Medicaid-funded nursing facility or community-based care services.

**4.6 An independent physician.** An independent physician is a physician chosen by the ALF resident and who has no financial interest in the ALF, directly or indirectly, as an owner, officer, or employee or as an independent contractor with the residence.

**4.7 State facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services.** There are 15 state facilities in the Commonwealth that provide inpatient services for persons with mental illness or mental retardation.

**4.8 Acute care hospitals.** There are 130 hospitals in the Commonwealth, many of which contract with DMAS to perform PAS or to complete the UAI for a home- and community-based waiver program. Veterans Administration hospitals could participate if their physicians enroll as a Medicaid provider for assessments. These entities are limited to the initial assessments. Qualified emergency room staff could complete the assessment and authorization for ALF services if their hospital has a contract with DMAS to perform PAS.

**4.9 Department of Corrections, Community Release Units or the Department's designee.** Staff trained to complete the UAI may complete the initial assessment only for inmates who may be appropriate for ALF services and have reached their appropriate release status. The authority to conduct an initial assessment for ALF services does not extend to those inmates who might be appropriate for nursing facility placement.

All of the above assessors may conduct initial assessments as well as annual reassessments with the exception of:

- State facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)
- Acute care hospitals
- Department of Corrections Community Release Units or the Department's designee.

These three entities may **only** complete the initial assessment and must send a copy of the UAI, DMAS-96, and reassessment date to the Adult Services Supervisor of the LDSS where the individual will reside.

The primary source of training of the completion of the UAI is the Virginia Institute for Social Services Activities (VISSTA) of Virginia Commonwealth University. Courses are offered periodically statewide. A certificate is provided after successful completion of course. It is strongly recommended that all public human services agency assessors complete this or another authorized course on completion of the UAI. For more information, please go to <http://www.vcu.edu/vissta/>.

## **5. REQUEST FOR ASSESSMENT**

THE UNIFORM ASSESSMENT INSTRUMENT SHALL BE COMPLETED WITHIN 90 DAYS PRIOR TO THE DATE OF ADMISSION TO THE ASSISTED LIVING FACILITY. IF THERE HAS BEEN A SIGNIFICANT CHANGE IN THE INDIVIDUAL'S CONDITION SINCE THE COMPLETION OF THE UNIFORM ASSESSMENT INSTRUMENT WHICH WOULD AFFECT THE ADMISSION TO AN ASSISTED LIVING FACILITY, A NEW UNIFORM ASSESSMENT INSTRUMENT SHALL BE COMPLETED.

An assessment to determine the need for assisted living facility (ALF) care must be completed for *any* AG individual applying for ALF admission. The assessment must be completed prior to the individual's admission to the ALF.

The adult seeking placement, a family member, the physician, a community health services or social services professional, or any other concerned individual in the community can initiate a request for assessment. If the individual is in the community at the time of referral, a local assessor will conduct the initial evaluation.

Under current statutory requirements, assessments completed by AAAs, CSBs/BHAs, CILs, state MH/MR facilities, physicians, or state correctional facilities will be accepted as authorizations only for residential or assisted living services. The local PAS team may authorize any of the services in the continuum of long-term care, including admission to an ALF. It is, therefore, important that all assessors attempt to determine during intake whether the person may require nursing facility placement or a Medicaid-funded community-based service. If so, assessors who are not authorized to perform PAS should refer the individual to a local PAS team to complete the assessment.

## **6. RESPONSE TO ASSESSMENT REQUEST**

When a referral is made to a local assessor to conduct an assessment, a contact must be made as soon as possible after receipt of the referral. The assessment process should be completed as soon as possible. All assessments must be completed, a decision letter sent to the individual assessed, and any referrals for services made within two weeks of the receipt of the referral. If the assessor contacted cannot meet this response time, the assessor should refer this assessment to another assessor.

New applicants for AGs must be assessed within the 45-day processing time for the AG application. If the assessment is not completed within 45 days after the AG application is submitted, the eligibility worker may extend the pending status of the AG case an additional 15 days. If action to approve or deny the application for AG cannot be taken within 45 days, a notice must be sent to the applicant explaining the reason action was not taken.

If an individual is not currently receiving an AG or has not made application for an AG subsequent to ALF admission, the ALF assessment process is completed by an individual authorized to complete private pay UAI's.

## **7. DETERMINATION OF ELIGIBILITY FOR AN AUXILIARY GRANT**

The assessor must first determine if the individual to be assessed is already receiving an AG or has applied for an AG. If the individual is not currently receiving AG, the assessor must advise the individual and/or the individual's family to contact the LDSS to initiate the AG eligibility determination. The LDSS eligibility worker in the locality in which the individual resided prior to admission to the ALF must be informed that ALF placement is being sought.

The eligibility determination process must begin early so that the assigned eligibility worker will have sufficient time to complete the eligibility determination. The assessor should instruct the individual and family to prepare for the eligibility process by taking proof of income, copies of bank statements, life insurance policies, savings certificates, stocks, bonds, etc., to the eligibility appointment.

At the time the request is made, the assessor must inform the individual or family that:

1. The authorization for public payment for ALF services does not mean that the individual will definitely receive an AG or become financially eligible for Medicaid;
2. Financial eligibility must be determined by an eligibility worker from the LDSS;
3. Medicaid cannot reimburse for services unless the individual has been determined to be financially eligible; and
4. The individual may have a responsibility for partial payment for public-funded services, if authorized.

The assessor shall conduct a preliminary screening of an individual's financial status and estimate whether the individual would likely be eligible for an AG. However, an assessor would still be reimbursed for an assessment of an individual who is in good faith thought to be AG eligible, but later determined to be not financially eligible for an AG.

## **8. CONSENT TO EXCHANGE INFORMATION**

Prior to collecting any information as a part of the assessment process, the assessor must advise individuals of the purpose for seeking this information and the consequences of failure to provide information, and must obtain a Consent to Exchange Information Form (see Appendix C). Any legally competent individual who refuses to sign the consent form must be advised that the assessor may not proceed with the assessment process without a signed consent form. Any individual who is not legally competent to sign the consent

form must have a legally authorized representative sign the consent form prior to completion of the assessment process. The consent form allows the assessor to share information obtained through the assessment with ALFs or public human service agencies. These entities are required by law to maintain the individual's confidentiality.

For the "Consent to Exchange Information," responsible persons are: spouses, legal guardian, and persons who have power of attorney. DMAS will accept the consent of any primary caregiver as the "Responsible Person" for Medicaid programs. Agencies should refer to their own agency policies about releasing information.

ALFs must also be aware of rules governing electronic transactions involving use of an individual's health records according to the Health Insurance Portability and Accountability Act (HIPAA). HIPAA includes standards relating to health information being sent over digital networks.

## **9. OUT-OF-STATE APPLICANTS TO ASSISTED LIVING FACILITY CARE**

All assessments completed for public pay residents must be completed during a face-to-face visit, such as to the facility or the individual's home. The only exception may be the screening assessment that may be completed by telephone by the Virginia-authorized assessor for out-of-state applicants. However, the Virginia assessor having jurisdiction must verify this assessment information by a face-to-face visit to the applicant within 7 days of the adult's admission to a Virginia ALF. All required paperwork must be completed.

## **10. COMPLETION OF THE VIRGINIA UNIFORM ASSESSMENT INSTRUMENT (UAI)**

THE ASSESSMENT SHALL BE CONDUCTED WITH THE DEPARTMENT-DESIGNATED UNIFORM ASSESSMENT INSTRUMENT WHICH SETS FORTH A RESIDENT'S CARE NEEDS. THE UNIFORM ASSESSMENT INSTRUMENT IS DESIGNED TO BE A COMPREHENSIVE, ACCURATE, STANDARDIZED, AND REPRODUCIBLE ASSESSMENT OF INDIVIDUALS SEEKING OR RECEIVING LONG-TERM CARE SERVICES.

A manual entitled *User's Manual: Virginia Uniform Assessment Instrument* provides thorough instructions regarding completion of the assessment and must be utilized in the completion of the UAI. Copies of the public pay and private pay UAI user's manuals are available at: [http://www.dss.virginia.gov/family/as/uai\\_manual.cgi](http://www.dss.virginia.gov/family/as/uai_manual.cgi)

The UAI is comprised of a short assessment and a full assessment. The short assessment (Part A or pages 1-4) plus questions on behavior and medication management is designed to briefly assess the individual's need for services and to determine if a full assessment (Parts A+B or entire UAI) is needed. Based on a prior study of ALF residents, it was determined that about 65 percent of the assessments will be short assessments for residential living residents, and 35 percent of assessments will be full

assessments for assisted living residents. The UAI is designed to be a standardized and reproducible assessment of individuals seeking or receiving long-term care services and is used by public human services agencies statewide for a variety of purposes.

The information is documented on the UAI. The UAI is shown in Appendix C of this manual. A copy of the UAI is available at: <http://www.dss.virginia.gov/family/as/forms.cgi>.

The assessment focuses on the functional dependencies and other needs of the individual with emphasis on assessing the total individual as **he functions in his usual environment**.

THE ASSESSOR SHALL CONSULT WITH OTHER APPROPRIATE HUMAN SERVICE PROFESSIONALS AS NEEDED TO COMPLETE THE ASSESSMENT.

It is very important that an accurate assessment of the individual's functional status and other needs be recorded on the UAI, since this information forms the basis for a determination of whether the individual meets the assisted living facility level of care criteria. The assessor must note the individual's degree of independence or dependence in various areas of functioning.

The process used to assess dependency considers how the person is currently functioning (e.g., is the individual actually receiving assistance to perform an activity of daily living) and whether the person's functioning demonstrates a need for assistance to perform the activity (i.e., the individual does not receive assistance to bathe but is unable to adequately complete his or her bath, and, as a consequence, has recurrent body rashes). If the person currently receives the assistance of another person to perform the activity, or if the person demonstrates a need for the assistance of another person to complete the activity, the person is deemed dependent in that activity. The need of the individual for prompting or supervision in order to complete an activity qualifies as a dependency in that activity.

The individual's care needs must be considered and clearly documented on the UAI to support the outcome of the assessment (i.e., qualifying or not qualifying for placement in an ALF). This determination is based on a view of the individual's total needs, both functional and medical. Information gathered on the UAI will allow the assessor to determine whether the individual meets the level of care criteria for ALF placement. An individual must meet these criteria to be considered for public-funded ALF placement.

## **11. COMPLETING THE SHORT FORM OF THE UAI**

For public pay individuals, the short form (first four pages of the UAI) plus an assessment of the individual's medication management ("How do you take your medicine?" question on page 5 of the UAI) and behavior ("Behavior Pattern" section on page 8 of the UAI) must be completed. (Note: DMAS will only reimburse the assessor at the short-form rate if that is

all that is needed even if the full assessment is completed. DMAS will monitor the completion of assessments to ensure that reimbursements are appropriate.)

Assessors will complete only the short assessment when the individual is:

1. Rated dependent in only one of seven activities of daily living (ADLs); OR
2. Rated dependent in one or more of four selected instrumental activities of daily living (IADLs); OR
3. Rated dependent in medication administration.

In determining whether a person is dependent in medication administration (i.e., “administered by professional staff”), this choice should be made when a professional staff person is necessary to **assess** the individual and **evaluate** the efficacy of the medications and treatment. The medication management course for medication aides and subsequent certification does not qualify an individual to be considered as “administered by professional staff.”

For short assessments completed for AG recipients, the first four pages plus questions on medication administration on page 5 and behavior pattern on page 8 must be completed. An add-on page which includes these two variables or page 2 of the private pay UAI may be used. Licensing regulations for admission to an ALF also require an evaluation of the individual's orientation and the absence of prohibited conditions. These variables are included on the add-on page to facilitate the admission process. A copy of the add-on page is shown in Appendix C. A grid for the combination variable behavior pattern and orientation is shown in Exhibit 5 of this chapter. There is an optional worksheet available in Appendix C that will help the assessor to quickly determine the level of care at which the individual is assessed.

## **12. COMPLETING THE FULL ASSESSMENT**

If, upon completing the short assessment, it is noted that the individual is rated dependent in two or more ADLs or is rated dependent in behavior pattern, then a full assessment must be completed. DMAS will monitor assessments to ensure that the appropriate version (i.e., short vs. full) is completed.

Failure to complete the full assessment for “Assisted Living” authorizations will result in non-payment to the provider.

## **13. PROHIBITED CONDITIONS**

Assessors must also determine that individuals do not have any of the prohibited conditions listed below before authorizing placement in an ALF. If any of these conditions

are present, the assessor must document that they are present on the UAI, and the AG recipient or applicant is not eligible for ALF placement. If appropriate, contact a health care or mental health care professional for assistance in the assessment of these prohibited conditions.

State law prohibits admission or retention of individuals in an ALF when they have any of the following conditions or care needs (bold text is used to indicate language from the law):

**13.1 Ventilator dependency:** A situation where a ventilator is used to expand and contract the lungs when a person is unable to spontaneously breathe on his or her own. Some individuals require the ventilator for all of their respirations, while others require it in the event that they are unable to breathe on their own.

**13.2 Dermal ulcers stage III and IV except those stage III ulcers which are determined by an independent physician to be healing** and care is provided by a licensed health care professional under a physician's treatment plan: Dermal ulcers include pressure ulcers (e.g., bed sores, decubitus ulcers, pressure sores) which may be caused by pressure resulting in damage of underlying tissues and stasis ulcers (also called venous ulcer or ulcer related to peripheral vascular disease) which are open lesions, usually in the lower extremities, caused by a decreased blood flow from chronic venous insufficiency. The prohibition is based on the size, depth, and condition of the wound regardless of the cause. The following is a summary of dermal ulcer stages:

**13.2.1 Stage I:** A persistent area of skin redness, without a break in the skin, that does not disappear when pressure is relieved.

**13.2.2 Stage II:** A partial thickness loss of skin layers that present clinically as an abrasion, blister, or shallow crater.

**13.2.3 Stage III:** A full thickness of skin lost, exposing the subcutaneous tissues; presents as a deep crater with or without undermining adjacent tissue. The wound extends through all layers of the skin and is a primary site for a serious infection to occur. The goals and treatments are to alleviate pressure and covering and protecting the wound as well as an emphasis on nutrition and hydration. Medical care is necessary to promote healing and to treat and prevent infection. This type of wound progresses very rapidly if left unattended.

**13.2.4 Stage IV:** A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. This wound extends through the skin and involves underlying muscle, tendons, and bone. The diameter of the wound is not as important as the depth. This is very serious and can produce a life-threatening infection, especially if not aggressively treated. All of the goals of protecting, cleaning, and alleviation of pressure on the area still apply. Nutrition and hydration is now critical. Without adequate nutrition, this wound will not heal. This wound requires medical care by someone skilled in wound care. Surgical removal of the necrotic or decayed tissue is often used on wounds of larger diameter.

**13.3 Intravenous therapy or injection directly into the vein except for intermittent intravenous therapy managed by a health care professional licensed in Virginia.** If the course of treatment extends beyond a two-week period, an evaluation by the licensed health care professional is required every two weeks.

Intravenous (IV) therapy means that a fluid or drug is administered directly into the vein. Examples may include the infusion of fluids for hydration, antibiotics, chemotherapy, narcotics for pain, and total parenteral nutrition (TPN).

Intermittent intravenous therapy may be provided for a limited period of time on a daily or periodic basis by a licensed health care professional under a physician's treatment plan. When a course of treatment is expected to be ongoing and extends beyond a two-week period, evaluation is required at two-week intervals by the licensed health care professional.

**13.4 Airborne infectious disease** in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold.

**13.5 Psychotropic medications without appropriate diagnosis and treatment plans.** Psychopharmacologic or psychotropic drugs include any drug prescribed or administered with the intent of controlling mood, mental status, or behavior. They include such drug classes as antipsychotic, antidepressants, and the anti-anxiety/hypnotic class. Examples include, but are not limited to, Abilify, Amytal, Atarax, Ativan, Benadryl, Celexa, Clozaril, Dalmane, Depakene, Depakote, Desyrel, Effexor, Elavil, Haldol, Lexapro, Librium, Lithium, Luvox, Klonopin, Mellaril, Navane, Norpramine, Pamelor, Paxil, Prozac, Remeron, Restoril, Risperdal, Seroquel, Serax, Serzone,

Stelazine, Thorazine, Tofranil, Tranxene, Valium, Vistaril, Wellbutrin, Xanax, Zoloft, and Zyprexa.

- 13.6 Nasogastric tubes:** A nasogastric (NG) tube is a feeding tube inserted into the stomach through the nose. It is used when the individual is unable to manage oral nutrition or feeding.
- 13.7 Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube.** Gastric tube feeding is the use of any tube that delivers food, nutritional substances, fluids and/or medications directly into the gastrointestinal system. Examples include, but are not limited to, gastrostomy tube (GT), jejunostomy tube (JT), and percutaneous endoscopic gastrostomy tube (PEG).
- 13.8 Individuals presenting an imminent physical threat or danger to self or others.** Imminent physical threat cannot be classified by a diagnosis; the determination is made based upon the behavior of the resident.
- 13.9 Individuals requiring continuous licensed nursing care (seven days a week, twenty-four hours a day).** Continuous licensed nursing care means around-the-clock observation, assessment, monitoring, supervision, or provision of medical treatment by a licensed nurse. Residents requiring continuous licensed nursing care may include:
- 13.9.1** Individuals who have a medical instability due to complexities created by multiple, interrelated medical conditions; or
  - 13.9.2** Individuals with a health care condition with a high potential for medical instability.
- 13.10 Individuals whose physician certifies that placement is no longer appropriate.**
- 13.11 Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by the UAI and meet Medicaid nursing facility level of care criteria as defined in the State Plan for Medical Assistance.** Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on the uniform assessment instrument. An individual who can participate in any way with the performance of the activity is not considered to be totally dependent.
- 13.12 Individuals whose health care needs cannot be met in the specific assisted living facility as determined by the residence.**

## **14. PRIVATE PAY INDIVIDUALS ONLY/EXCEPTIONS OF CERTAIN PROHIBITED CONDITIONS**

At the request of the private pay individual, care for the conditions or care needs specified in 13.3 and 13.7 above may be provided to a individual in an ALF by a physician licensed in Virginia, a nurse licensed in Virginia under a physician's treatment plan, or by a home care organization licensed in Virginia when the resident's independent physician determines that such care is appropriate for the resident. These exceptions do not apply to AG recipients. When care for a resident's special medical needs is provided by licensed staff of a home care agency, the ALF staff may receive training from the home care agency staff in appropriate treatment monitoring techniques regarding safety precautions and actions to take in case of emergency.

## **15. PSYCHOSOCIAL ASSESSMENT**

The presence of cognitive problems, mental impairments and substance abuse can have an impact on the ability of the individual to live in an ALF and the ability of the ALF staff to provide proper care. If the UAI indicates dependencies in the Psycho-social Assessment section (section 4) of the UAI additional assessment requirements for admission to an ALF must be met (See Chapter IV) See Appendix K of the *User's Manual: Uniform Assessment Instrument*, July 2005, for more information. A copy of Appendix K is available as Exhibit 1 in Chapter IV.

## **16. ASSISTED LIVING FACILITY CRITERIA**

THE APPROPRIATE LEVEL OF CARE MUST BE DOCUMENTED ON THE UNIFORM ASSESSMENT INSTRUMENT, COMPLETED IN A MANNER CONSISTENT WITH THE DEFINITIONS OF ACTIVITIES OF DAILY LIVING AND DIRECTIONS PROVIDED IN THE USER'S MANUAL: VIRGINIA UNIFORM ASSESSMENT INSTRUMENT.

The criteria for assessing an individual's eligibility for public payment for ALF care and services consist of the following components:

1. Functional capacity (the degree of assistance an individual requires to complete activities of daily living or instrumental activities of daily living);
2. Medication administration; and
3. Behavior pattern/orientation.

### **16.1 CRITERIA FOR RESIDENTIAL LIVING**

In order to qualify for public payment for ALF care, an individual must meet the criteria described below:

INDIVIDUALS MEET THE CRITERIA FOR RESIDENTIAL LIVING AS DOCUMENTED ON THE UNIFORM ASSESSMENT INSTRUMENT WHEN AT

LEAST ONE OF THE FOLLOWING DESCRIBES THEIR FUNCTIONAL CAPACITY:

1. RATED DEPENDENT IN ONLY ONE OF SEVEN ADLS (I.E., BATHING, DRESSING, TOILETING, TRANSFERRING, BOWEL FUNCTION, BLADDER FUNCTION, AND EATING/FEEDING).
2. RATED DEPENDENT IN ONE OR MORE OF FOUR SELECTED IADLS (I.E., MEAL PREPARATION, HOUSEKEEPING, LAUNDRY, AND MONEY MANAGEMENT).
3. RATED DEPENDENT IN MEDICATION ADMINISTRATION.

## **16.2 CRITERIA FOR ASSISTED LIVING**

INDIVIDUALS MEET THE CRITERIA FOR ASSISTED LIVING AS DOCUMENTED ON THE UNIFORM ASSESSMENT INSTRUMENT WHEN AT LEAST ONE OF THE FOLLOWING DESCRIBES THEIR CAPACITY:

1. RATED DEPENDENT IN TWO OR MORE OF SEVEN ADLS.
2. RATED DEPENDENT IN BEHAVIOR PATTERN (I.E., ABUSIVE, AGGRESSIVE, AND DISRUPTIVE).

## **17. INDEPENDENT LIVING STATUS**

Individuals who are assessed as independent can be admitted into an ALF. A person does not have to meet the residential level of care criteria to live in an ALF licensed for residential care. Individuals who are assessed as independent are **NOT** eligible for AG payments unless they were public pay residents prior to February 1, 1996. Persons who are independent do not need the services provided by an ALF and therefore cannot receive public monies for those services, except for those who became public pay residents under the previous regulation and have been grandfathered.

## **18. OUTCOMES OF ALF ASSESSMENTS**

The possible outcomes from ALF assessment may include:

1. A recommendation for ALF care;
2. Referral to a preadmission screening (PAS) team to review if the individual is appropriate for Medicaid-funded community-based care or nursing facility care;

3. Referrals to other community resources (non-Medicaid-funded) such as health services, adult day care centers, home-delivered meals, etc.; or
4. A determination that services are not required.

## **19. AUTHORITY FOR AUTHORIZATION OF PUBLIC PAYMENT**

THE ASSESSOR IS RESPONSIBLE FOR AUTHORIZING THE INDIVIDUAL FOR THE APPROPRIATE LEVEL OF CARE FOR ADMISSION TO AND CONTINUED STAY IN AN ASSISTED LIVING FACILITY.

After the assessor has completed an assessment and established a level of care, the assessor is responsible for authorizing the appropriate services. During the authorization process, the assessor, with input from the individual being assessed, will decide what services, if any, are needed; who will provide the services; and the setting where services will be provided. The assessor will identify the available community services and make referrals as appropriate. The appropriate level of care must be documented on the Medicaid Funded Long-Term Care Services Authorization (DMAS-96). See Appendix C for a copy of the DMAS-96.

In those instances when the assessment documentation does not clearly indicate that the individual meets ALF criteria, public funding for these services cannot be authorized. Any information that is needed to support the assessor's level-of-care decision must be documented on the UAI.

DMAS does, however, have the ultimate responsibility for assuring appropriate placement for assisted living services and thus can overturn any decision made by the assessor. Any authorization made by the assessor is subject to change based on any change that occurs in the individual's condition or circumstances between the time the authorization occurs and the admission of the individual to an ALF. All applicants to and residents of ALFs for which assessment and/or targeted case management services are provided have the right to appeal the outcome of any assessment. See the "Right to Appeal", section 25, of this chapter for additional information.

## **20. INITIAL ASSESSMENT PACKAGE**

UPON COMPLETION OF THE UNIFORM ASSESSMENT INSTRUMENT FOR ADMISSION, A SIGNIFICANT CHANGE IN THE RESIDENT'S CONDITION, OR FOR THE ANNUAL REASSESSMENT, THE CASE MANAGER OR A QUALIFIED ASSESSOR SHALL FORWARD TO THE LOCAL DEPARTMENT OF SOCIAL SERVICES FINANCIAL ELIGIBILITY WORKER IN THE APPROPRIATE AGENCY OF JURISDICTION, IN THE FORMAT SPECIFIED BY THE DEPARTMENT, THE EFFECTIVE DATE OF ADMISSION OR CHANGE IN LEVEL OF CARE.

## 21. REFERRAL TO ASSISTED LIVING FACILITY

When a recommendation is made that an individual meets ALF level of care (either residential care or assisted living care services), the assessor will document this decision on the UAI and the Medicaid Funded Long-Term Care Services Authorization (DMAS-96) and prepare an assessment package. The initial assessment package is sent to:

First Health Services  
P.O. Box 85083  
Richmond, Virginia 23285-5083

The initial assessment package sent to First Health Services must include:

- **DMAS-96** (Medicaid Funded Long-Term Care Services Authorization). On the DMAS-96, #11 will be indicated for residential living care and #12 for regular assisted living. If #12 is authorized, the assessor must also enter the ALF provider number and date of the ALF start of care. If the individual requires Medicaid-funded targeted case management, this would also be indicated. Also note the effective date of authorization. The assessor writes his or her agency's provider number in the first line of the space for "Level I Screening Identification" on the DMAS-96. The second line is used for PAS only.
- **Virginia Uniform Assessment Instrument (UAI)**, either short form or long-form, as appropriate. A copy of the UAI is acceptable.

**In addition to the initial assessment package, the assessor must distribute the following:**

- **To the LDSS Eligibility Worker**, the assessor must send a copy of the DMAS-96 to verify eligibility. A copy of the DMAS-96 is sent to the appropriate LDSS eligibility worker based on where the individual lived prior to placement in a facility or Adult Foster Care. The eligibility worker does not need to receive a copy of the UAI.
- **To the ALF**, the assessor sends the original UAI, DMAS-96, and decision letter. (See Exhibits 2-4.)
- **To the individual being assessed**, the assessor sends a decision letter.
- **The assessor** keeps copies of the UAI, DMAS-96, consent form, and decision letter.

## **22. REFERRALS TO MEDICAID-FUNDED COMMUNITY-BASED CARE OR NURSING FACILITY**

Community-based care (CBC) or nursing facility services may be considered when the assessor completes an assessment and determines that an individual meets the criteria for nursing facility care and is at risk of nursing facility placement unless additional help is received. If the assessor feels that community-based care or nursing facility services are needed, the assessor must refer the individual for authorization of these services. CBC services include AIDS/ARC (Acquired Immune Deficiency Syndrome/AIDS-related complex) services, personal care, adult day health care, and respite care. Hospital screening teams can authorize all services, but must have a physician's signature for community-based care or nursing facility authorizations.

If the assessor is from a local department of social services, the UAI is referred to a nurse of the local department of health who will need to make an on-site visit and complete the authorization on the DMAS-96. Both parties will be reimbursed at the nursing facility (NF) assessment rate. The assessment is considered a NF assessment; no additional payment is made for the ALF assessment.

If the assessor is another local public human services agency (i.e., AAA, CSB/BHA, or CIL) or a physician, but not a local department of social services, the original UAI is referred to the local department of health and becomes a nursing home preadmission screening. All PAS procedures, including a home visit, are required. The original assessor will complete the DMAS-96, indicating "None" for services recommended and submit the paperwork to DMAS for payment. The local departments of health and social services will be reimbursed as a PAS for completing a NF assessment by completing a different DMAS-96.

When state MH/MR facility staff determines that an individual requires nursing facility placement or Medicaid-funded community-based services, they shall follow the current PAS process that is to send the paperwork to DMAS for authorization of nursing facility or community-based care services.

DMAS staff will know whether to reimburse as an ALF or PAS assessment by determining if there are one or two provider numbers listed on the DMAS-96. If a PAS team assesses an individual for NF services, and it is determined that ALF services are needed, the team would be reimbursed at the PAS rate.

DMAS has the right to deny payment for any assessment that has not been completed according to DMAS policies and procedures.

## **23. REFERRALS TO COMMUNITY RESOURCES (NON-MEDICAID-FUNDED)**

When the assessor determines that an individual requires assistance in the home and can be adequately maintained by a community service or combination of services, the assessor will initiate referrals. Depending upon the type of service required, the assessor will make the referral to the appropriate agency and assure that the individual and family understand how to receive services.

It is essential for assessors to maintain current information on available community resources, such as health services, licensed ALFs, adult day care centers, home-delivered meals, etc., to assist in developing alternatives to long-term institutionalization.

**When referrals are made to non-Medicaid-funded community services, the assessor completes the following:**

- **DMAS-96.** On the DMAS-96, #8, "Other Services Recommended" would be authorized and the reason and resources to be used will be documented on the UAI.
- **UAI,** either short or long form as appropriate.

The assessment package is sent to:

First Health Services  
P.O. Box 85083  
Richmond, Virginia 23285-5083

**In addition to the initial assessment package, the assessor must distribute the following information:**

- **To the community service agency,** the assessor sends a copy of the UAI and the Consent to Exchange Information form.
- **To the individual being assessed,** the assessor sends a decision letter (see Exhibits).
- **The assessor** keeps copies of the UAI, the DMAS-96, consent form, and decision letter.

## **24. DETERMINATION THAT SERVICES ARE NOT REQUIRED**

When the assessor determines that an individual is fully self-care or can be safely and adequately maintained in the home with assistance from relatives, friends, or neighbors and requires no additional monitoring or supervision, the assessor makes no referrals.

**When no referrals for services are required, the assessor completes the following assessment package:**

- **DMAS-96.** On the DMAS-96, #0, "No other services recommended"; document reason on the UAI.
- **UAI,** either short or long form as appropriate.

The assessment package is sent to:

First Health Services  
P.O. Box 85083  
Richmond, Virginia 23285-5083

**In addition to the initial assessment package, the assessor must distribute the following information:**

- **To the LDSS Eligibility Worker,** the assessor must send a copy of the DMAS-96.
- **To the individual being assessed,** the assessor sends a decision letter.
- **The assessor** keeps copies of the UAI, DMAS-96, the consent form, and decision letter.

## **25. TIME LIMITATION ON ASSESSMENTS**

An authorized assessor's approval decision and the completed UAI regarding an individual's appropriateness for ALF placement are valid for 12 months or until an individual's functional or medical status changes, and the change indicates the individual may no longer meet the authorized level of care criteria.

New assessments are not needed when a current assessment has been completed within 12 months and no change in level of care has occurred for the following situations: 1) lapse in financial eligibility; 2) transfer from one ALF to another; 3) respite care residents; or 4) discharge back to the ALF from the hospital.

## **26. RIGHT OF APPEAL**

ASSESSORS SHALL ADVISE ORALLY AND IN WRITING ALL APPLICANTS TO AND RESIDENTS OF ASSISTED LIVING FACILITIES FOR WHICH ASSESSMENT OR TARGETED CASE MANAGEMENT SERVICES OR BOTH ARE PROVIDED OF THE RIGHT TO APPEAL THE OUTCOME OF THE ASSESSMENT, ANNUAL REASSESSMENT, OR DETERMINATION OF LEVEL OF CARE. APPLICANTS FOR AUXILIARY GRANTS WHO ARE DENIED AN AUXILIARY GRANT BECAUSE THE

ASSESSOR DETERMINES THAT THEY DO NOT REQUIRE THE MINIMUM LEVEL OF SERVICES OFFERED IN THE RESIDENTIAL CARE LEVEL HAVE THE RIGHT TO FILE AN APPEAL WITH THE DEPARTMENT OF SOCIAL SERVICES UNDER § 63.2-517 OF THE CODE OF VIRGINIA. A DETERMINATION THAT THE INDIVIDUAL DOES NOT MEET THE CRITERIA TO RECEIVE ASSISTED LIVING IS AN ACTION WHICH IS APPEALABLE TO DMAS.

Any action taken by an assessor which affects the individual's receipt of services administered by the Medicaid program is an action that may be appealed to DMAS. The assessor, by letter, must inform the individual and the referral source of the assessment decision to authorize or deny Medicaid payment for long-term care services and indicate the reason(s) for the decision. Any individual wishing to appeal should notify the Appeals Division, DMAS, in writing, of his or her desire to appeal within 30 days of the receipt of the assessor's decision letter. The following statement must be included in every decision letter (denial or approval):

**“You may appeal this decision by notifying, in writing, the Appeals Division, Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219. This written request for an appeal must be filed within thirty (30) days of the date of this notification.”**

Any request for an appeal received by the DMAS Appeals Division must be validated and a hearing scheduled with the appellant. A final decision on the appeal must be completed within 90 days of the date the request for an appeal is received. The Appeals Division will be responsible for determining the relevant parties to be involved in the hearing process. See Exhibits 2-4 at the end of this chapter for sample approval and denial letters.

If the individual wishes to appeal a decision to deny assisted living services, the assessor will be notified that a summary of his or her decision must be prepared, and an appeal hearing will be scheduled which the assessor must attend.

## EXHIBIT 1: ASSESSMENT PROCESS

Step 1: Contact	Request for assessment is made. Assessor makes contact with the individual/requester. Verify AG eligibility or that application for AG has been made. If possible, conduct a preliminary screening to determine if there are any prohibited conditions or other medical issues that may require more care than is available in an ALF. Refer to the PAS team, if appropriate.
Step 2: UAI	Conduct a face-to-face visit. Get consent to release information. Assessor completes the appropriate UAI. If UAI has been completed in last 90 days, and there are no changes, do not complete a new UAI. If individual meets NF criteria, stop assessment process. Refer to PAS team for authorization of NF or CBC services.
Step 3: Prohibited Conditions	Assessor determines if individual has a prohibited condition. The AG recipient is NOT eligible for ALF placement if he has a prohibited condition. Stop assessment process and refer to the PAS team or to other services.
Step 4: Determine Level of Care	Determine individual's level of care using ALF criteria (i.e., residential or assisted living). Complete DMAS-96 and prepare authorization letter about approval or denial of ALF services to the individual.
Step 5: ALF Availability/ Case Management	Discuss with the individual his choice of ALF. Ensure that ALF has the appropriate license for the person's level of care and is enrolled as a Medicaid provider. Verify that ALF can provide requested services or if they are available in the community. Determine if the individual requires only the 12-month reassessment or ongoing Medicaid-funded targeted ALF case management services. If only 12-month reassessment, continue. If case management services needed, arrange for a case manager.
Step 6: Notifications for Initial Assessments & Level of Care Changes	To DMAS, send copies of DMAS-96 and UAI. To LDSS eligibility worker, send copy of DMAS-96. To ALF, send the DMAS-96 and UAI. To individual, send original decision letter. Assessor keeps copies of the UAI, DMAS-96, consent form, and decision letter. Assessment process must be completed within 2 weeks of receipt of the referral.
Step 7: Plan Reassessment	At least every 12 months, perform reassessment. Original assessor is responsible for reassessment; if unwilling or unable to do so, original assessor is responsible to engage another assessor to do the reassessment. If original assessor is hospital staff, state facility staff, or a community release unit of a correctional facility, he must refer reassessment responsibility to another assessor. In this case, the new assessor must be identified at time of admission.
Step 8: Reassessment Notification	To DMAS, send copies of ALF Eligibility Communication Document, UAI, and CMS-1500. To LDSS eligibility worker, send copy of ALF Eligibility Communication Document. To ALF, send the UAI and ALF Eligibility Communication Document. To individual, send decision letter. Assessor keeps UAI, ALF Eligibility Communication Document, and CMS-1500.

## EXHIBIT 2: SAMPLE APPROVAL ASSISTED LIVING FACILITY LETTER

Date \_\_\_\_\_

Individual's Name/Address \_\_\_\_\_

Dear \_\_\_\_\_:

Virginia regulation requires that any individual seeking admission to an assisted living facility (ALF) be assessed to determine if he or she meets the level of care for an assisted living facility prior to the individual's placement. You were assessed on \_\_\_\_\_ (date) and it was determined that you meet criteria for:

- ☐ Residential living
- ☐ Assisted living
- ☐ Ongoing Medicaid-funded targeted case management

The assessor, in accordance with policy and procedures of the Department of Medical Assistance Services, has determined that you meet the level-of-care criteria necessary for assisted living facility placement. The assessor discussed with you the choice of facility services, and it was determined that assisted living facility placement would best meet your needs at the present time. The assessor is responsible for assessing your needs upon admission and, you will be assessed periodically thereafter in order to demonstrate that you continue to meet the criteria.

You may appeal this decision within thirty (30) days of receipt of this decision letter by writing to the Recipient Appeals Unit, Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219.

Sincerely,

Assessor

**EXHIBIT 3: SAMPLE DENIAL LETTER FOR ALF REGULAR ASSISTED LIVING OR  
ONGOING MEDICAID-FUNDED TARGETED ALF CASE MANAGEMENT**

Date \_\_\_\_\_  
Individual's Name/Address \_\_\_\_\_

Dear \_\_\_\_\_:

As an applicant/recipient of an Auxiliary Grant, you must be determined to need the level of care offered by an assisted living facility (ALF). You were assessed on \_\_\_\_\_ (date) and it was determined that you do not meet criteria for:

- ☐ Residential living
- ☐ Assisted living
- ☐ Ongoing Medicaid-funded targeted case management

The reason you were determined not to meet the criteria for the above-checked item is (note ***specific*** reason why the individual does not meet the criteria).

If you do not agree with this decision, you may write or call me to request a conference. If, after the conference, you still do not agree with the decision, you may request a hearing. If you do not want a conference, you may request a hearing without having a conference.

You must request a hearing within 30 days of the date this notice is postmarked. The hearing is a private, informal meeting with you, anyone you wish to bring, a Hearing Officer, and me. You will have the opportunity to tell the impartial Hearing Officer, who is a representative of the Virginia Department of Medical Assistance Services, why you disagree with the above decision. Your request must be mailed to:

Recipient Appeals Unit  
Department of Medical Assistance Services  
600 East Broad Street  
Richmond, Virginia 23219

Sincerely,

Assessor

c: Director, Appeals Division, DMAS  
Individual's Legal Guardian

**EXHIBIT 4. SAMPLE APPEALS LETTER FOR INDIVIDUAL NOT MEETING  
MINIMUM RESIDENTIAL ALF LEVEL OF CARE**

Date \_\_\_\_\_  
Individual's Name/Address \_\_\_\_\_

Dear \_\_\_\_\_ :

As an applicant/recipient of an Auxiliary Grant, you must be determined to need the level of care offered by an assisted living facility (ALF). You were assessed on \_\_\_\_\_ (date) and it was determined that you do not meet the minimum residential level of care guidelines because *(note specific reason why the individual does not meet the level of care)*.

If you do not agree with this decision, you may write or call me to request a conference. If, after the conference, you still do not agree with the decision, you may request a hearing. If you do not want a conference, you may request a hearing without having a conference.

You must request a hearing within 10 days of the date this notice is postmarked. The hearing is a private, informal meeting with you, anyone you wish to bring, a Hearing Officer, and me. You will have the opportunity to tell the impartial Hearing Officer, who is a representative of the Virginia Department of Social Services, why you disagree with the above decision. Your request must be mailed to:

Manager, Appeals and Fair Hearings  
Virginia Department of Social Services  
7 North Eighth Street  
Richmond, Virginia 23219

If you need help to request a hearing or appeal, please contact your service worker.

Sincerely,

Assessor

c: Manager, Appeals and Fair Hearings, VDSS  
Individual's Legal Guardian

**EXHIBIT 5. ALF ORIENTATION/BEHAVIOR PATTERN  
DETERMINATIONS**

	<b>Behavior</b>				
<b>Orientation</b>	Appropriate	Wandering/Passive Less Than Weekly	Wandering/ Passive More Than Weekly	Abusive/Aggressive /Disruptive Less Than Weekly	Abusive/Aggressive/ Disruptive More Than Weekly
Oriented	I	I	I	d	d
Disoriented --Some spheres --Some of the time	I	I	d	d	D
Disoriented --Some spheres --All of the time	I	I	d	d	D
Disoriented --All spheres --Some of the time	d	d	d	d	D
Disoriented --All spheres --All of the time	d	d	d	d	D

**I=Independent**

**d=Semi-dependent**

**D=Dependent**

## CHAPTER III: ANNUAL REASSESSMENT and CHANGE IN LEVEL OF CARE

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## **1. ANNUAL REASSESSMENT**

THE UNIFORM ASSESSMENT INSTRUMENT SHALL BE COMPLETED AT LEAST ANNUALLY ON ALL RESIDENTS OF ASSISTED LIVING FACILITIES. UNIFORM ASSESSMENT INSTRUMENTS SHALL BE COMPLETED AS NEEDED WHENEVER THERE IS A SIGNIFICANT CHANGE IN THE RESIDENT'S CONDITION. ALL UNIFORM ASSESSMENT INSTRUMENTS SHALL BE COMPLETED AS REQUIRED BY 22 VAC 40-745-20.

The purpose of the annual reassessment is the reevaluation of service need and utilization review. The assessor or case manager shall review each resident's need for services annually, or more frequently as required, to ensure proper utilization of services. The outcome of this review shall be communicated to the LDSS eligibility staff, DMAS, the assisted living facility (ALF), and the resident. All ALF residents must be reassessed at least annually. All applicants for an AG must have an assessment completed before AG payment can be issued.

It is the original assessor's responsibility to ensure that the required annual reassessments are completed. The assessor may refer the annual reassessment to another assessor, but no later than one month prior to the due date of the annual reassessment. An assessor is responsible for securing another assessor if he or she cannot continue to assess the individual. The reassessment then becomes the responsibility of the new assessor. Both the original assessor and the assessor to whom assessment responsibility is transferred should keep written communication. There is no required form for this communication.

The annual reassessment is based upon the date of the last completed assessment. The reassessment does not need to be performed in the same month as the financial eligibility redetermination. The financial eligibility worker in the local department of social services will need to have documentation in the eligibility record that there is a current assessment on file. A current assessment is one that is not older than 12 months.

## **2. WHO CAN CONDUCT THE ANNUAL REASSESSMENT?**

THE ANNUAL REASSESSMENT SHALL BE COMPLETED BY THE QUALIFIED ASSESSOR CONDUCTING THE INITIAL ASSESSMENT. IF THE ORIGINAL ASSESSOR IS NEITHER WILLING NOR ABLE TO COMPLETE THE ASSESSMENT AND ANOTHER ASSESSOR IS NOT AVAILABLE, THE LOCAL DEPARTMENT OF SOCIAL SERVICES WHERE THE RESIDENT RESIDES FOLLOWING PLACEMENT IN AN ASSISTED LIVING FACILITY SHALL BE THE ASSESSOR.

The following assessors can complete the annual reassessment:

- Local departments of social services
- Area agencies on aging

- Community services boards
- Centers for independent living
- Local departments of health
- Independent physician with a contract with DMAS

The annual reassessment is completed by:

- The assessor conducting the initial assessment;
- The qualified assessor of the Community Service Board (CSB)/Behavioral Health Authority (BHA) for clients of the CSB/BHA;
- The agency chosen by the resident for ongoing case management services; or
- The agency accepting the referral from the agency that completed the initial assessment. If no agency accepts the referral for reassessment, then the local department of social services where the resident resides, following placement in an ALF, is the assessor

### **3. TARGETED CASE MANAGEMENT FOR MENTAL HEALTH OR MENTAL RETARDATION**

CLIENTS OF A COMMUNITY SERVICES BOARD SHALL BE ASSESSED AND REASSESSED BY QUALIFIED ASSESSORS EMPLOYED BY THE COMMUNITY SERVICES BOARD.

**If a resident is receiving targeted case management services for mental illness or mental retardation, the agency case manager for this service must complete the reassessment as part of case management responsibilities for that individual.** DMAS will not reimburse them for the completion of the assessment since regular assessments are a required function of the targeted case management. This case management will be noted on the individual's UAI at the time of the initial assessment and the mental health case manager will be advised of the individual's authorization for ALF residence and the date when the reassessment is needed. The mental health case manager must complete the reassessment and follow the process of the annual reassessment.

### **4. WHO CANNOT CONDUCT THE ANNUAL REASSESSMENT?**

#### **4.1 ALF Staff**

ALF staff may not complete assessments, reassessments, or changes in level of care of ALF residents who are AG applicants or recipients. Designated ALF staff with documented training in the completion of the UAI may only complete assessments for private pay residents. Only qualified assessors of public human services agencies may perform public pay assessments.

## **4.2 ACUTE CARE HOSPITALS, STATE MH/MR FACILITIES, OR DEPARTMENT OF CORRECTIONS DESIGNEE**

Acute care hospitals, state mental health/mental retardation facilities, and correctional facilities may not complete the 12-month reassessment or provide Medicaid-funded targeted ALF case management. These groups may perform the initial assessments only.

When original assessments are completed by the acute care hospitals, state mental health/mental retardation facilities, and Community Release Units or Department of Corrections designee of correctional facilities, these responsibilities must be referred to another assessor as soon as possible, but no later than one month prior to the due date of the annual reassessment. The original assessor must send the UAI, the DMAS-96, and the reassessment date to the new assessor and notify the eligibility worker in the jurisdiction that the resident resides. The ALF must also be aware of reassessment dates and ensure that timely reassessments are completed.

## **5. TIMING OF THE REASSESSMENT**

In scheduling reassessments, DMAS will reimburse for assessments that are completed as soon as ten (10) months from the previous assessment. An annual reassessment that was completed, for example, on April 27<sup>th</sup> of the current year, could be completed as early as February 27 of the following year, and will be reimbursed. If a reassessment were completed prior to February 27 of the following year, the DMAS reimbursement system would reject the request for reimbursement.

If the reassessment is completed after the due date, then DMAS will deny reimbursement for services until such time as the reassessment was completed. Example: if the reassessment was due by April 27<sup>th</sup> of the current year, and the reassessment was not actually completed until June 27<sup>th</sup> of the current year, then the provider will not receive reimbursement from DMAS for services provided from April 27<sup>th</sup> until June 27<sup>th</sup>.

## **6. WHAT IS COMPLETED FOR THE ANNUAL REASSESSMENT PACKAGE?**

For annual reassessments, the assessor completes the following:

- 1. Assisted Living Facility Eligibility Communication Document** (shown in Appendix C). This form will notify the local eligibility worker in the LDSS where AG eligibility is determined that the resident continues to meet the criteria for an ALF placement so that AG eligibility can be redetermined. On the form, indicate that the reassessment is completed, whether the resident continues to meet criteria for ALF level of care. If the individual no longer resides in the ALF, indicate such in the space provided;

2. **Uniform Assessment Instrument (UAI)**, either short-form or long-form, as appropriate. If the assessor chooses not to complete a new UAI form and updates the existing UAI for the annual reassessment, the assessor must be sure that the copy submitted to DMAS for processing and data entry clearly indicates that it is a reassessment. (This may be done using a highlighter or colored ink at the top of the first page.) Only the initial assessment and one reassessment is permitted on UAI's submitted to DMAS. In addition, any changes that are made to the form must be clearly noted (as with a highlighter or colored ink) so that the changes will be easily recognized; and
3. **CMS-1500**: This completed billing invoice must be sent in order for the assessor to be reimbursed (except for MH/MR case management clients). See Chapter VII for billing instructions.

Please note that the DMAS-96 is NOT sent with an annual reassessment.

The annual reassessment package is sent to:

First Health Services  
P.O. Box 85083  
Richmond, VA 23285-5083

## 6.1 Notifications for Annual Reassessments

In addition to sending the above package to First Health Services, the assessor must distribute the following information:

1. **To the LDSS Eligibility Worker**, the assessor must send a copy of the Assisted Living Facility Eligibility Communication Document.
2. **To the ALF**, the assessor sends the original UAI and the Assisted Living Facility Eligibility Communication Document.
3. **To the individual being assessed**, the assessor sends a decision letter.
4. **The assessor** keeps a copy of the UAI, the Assisted Living Facility Eligibility Communication Document, and the CMS-1500.

If, during the reassessment, it is determined that a change in level of care has occurred, the assessor must treat the assessment not as a reassessment, but as a change in level of care. This means that the UAI and DMAS-96 are completed and not the ALF Eligibility Communication Document or the CMS-1500. See section 9 of this chapter for more information on changes in levels of care.

See Chapter VII for additional information on submitting the annual reassessment package to DMAS for reimbursement.

## **7. ANNUAL REASSESSMENTS FOR PRIVATE PAY RESIDENTS**

FOR PRIVATE PAY RESIDENTS, THE ASSISTED LIVING FACILITY SHALL ENSURE THAT ASSESSMENTS FOR ALL RESIDENTS AT ADMISSION AND AT SUBSEQUENT INTERVALS ARE COMPLETED AS REQUIRED IN THIS CHAPTER. THE ASSISTED LIVING FACILITY SHALL MAINTAIN IN THE RESIDENT'S RECORD THE RESIDENT'S UNIFORM ASSESSMENT INSTRUMENT AND OTHER RELEVANT DATA.

## **8. REQUEST FOR AN INDEPENDENT ASSESSMENT**

AT THE REQUEST OF THE ASSISTED LIVING FACILITY, THE RESIDENT, THE RESIDENT'S REPRESENTATIVE, THE RESIDENT'S PHYSICIAN, DSS, OR THE LOCAL DEPARTMENT OF SOCIAL SERVICES, AN INDEPENDENT ASSESSMENT USING THE UNIFORM ASSESSMENT INSTRUMENT SHALL BE COMPLETED TO DETERMINE WHETHER THE RESIDENT'S CARE NEEDS ARE BEING MET IN THE CURRENT PLACEMENT. AN INDEPENDENT ASSESSMENT IS AN ASSESSMENT THAT IS COMPLETED BY AN ENTITY OTHER THAN THE ORIGINAL ASSESSOR. THE ASSISTED LIVING FACILITY SHALL ASSIST THE RESIDENT IN OBTAINING THE INDEPENDENT ASSESSMENT AS REQUESTED. IF THE REQUEST IS FOR A PRIVATE PAY RESIDENT, AND THE INDEPENDENT ASSESSMENT CONFIRMS THAT THE RESIDENT'S PLACEMENT IS APPROPRIATE, THEN THE ENTITY REQUESTING THE INDEPENDENT ASSESSMENT SHALL BE RESPONSIBLE FOR PAYMENT OF THE ASSESSMENT, IF APPLICABLE.

An independent assessment is an assessment that is completed by an entity other than the original assessor; this may be another assessor within the same agency. At the request of the ALF, the resident's representative, the resident's physician, DSS, or the local department of social services, an independent assessment using the UAI is completed to determine whether the resident's care needs are being met in the current placement. An independent assessment is requested when one of the above entities questions the outcome of an assessment and desires a second assessment to be completed. The ALF shall assist the resident in obtaining the independent assessment as requested. If the outcome of the independent assessment is the same as the previous assessment, then the entity requesting the independent assessment may be held responsible for paying the independent assessment.

## **9. CHANGES IN LEVEL OF CARE**

DURING AN INSPECTION OR REVIEW, STAFF FROM EITHER THE DEPARTMENT, DMAS, OR THE LOCAL DEPARTMENT OF SOCIAL SERVICES MAY INITIATE A CHANGE IN LEVEL OF CARE FOR ANY ASSISTED LIVING FACILITY RESIDENT FOR

WHOM IT IS DETERMINED THAT THE RESIDENT'S UNIFORM ASSESSMENT INSTRUMENT IS NOT REFLECTIVE OF THE RESIDENT'S CURRENT STATUS.

The UAI must be completed or updated as needed whenever there is a significant change in the resident's condition that is expected to last more than 30 days or appears to warrant a change in the resident's approved level of care. A change in level of care assessment should be conducted within two weeks of receipt of the request for assessment when a permanent change in level of care is indicated, including when the resident presents with one or more of the prohibited conditions as described (see Chapter II) or no longer meets level of care criteria for which he was most recently assessed.

### **9.1 Who Can Complete an Assessment for a Change in Level of Care?**

The following entities can perform an assessment for a change in level of care:

- Local departments of social services;
- Area agencies on aging;
- Centers for independent living;
- Community services boards;
- Local departments of health;
- State facilities operated by DMHMRSAS;
- Acute care hospitals;
- An independent physician for residents of ALFs; or
- DMAS staff during an on-site review.

### **9.2 Temporary Changes in Condition**

Temporary changes in an individual's condition are those that can be reasonably expected to last less than 30 days. Such changes do not require a new assessment or update. Examples of such changes are short-term changes that resolve with or without intervention, changes that arise from easily reversible causes such as a medication change, short-term acute illness or episodic event, or a well-established, predictive, cyclic pattern of signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

### **9.3 Significant Changes in Condition Expected to Last Longer than 30 Days**

**"SIGNIFICANT CHANGE"** MEANS A CHANGE IN A RESIDENT'S CONDITION THAT IS EXPECTED TO LAST LONGER THAN 30 DAYS. IT DOES NOT INCLUDE SHORT-TERM CHANGES THAT RESOLVE WITH OR WITHOUT INTERVENTION, A SHORT-TERM ACUTE ILLNESS OR EPISODIC EVENT, OR A WELL-ESTABLISHED, PREDICTIVE, CYCLIC PATTERN OF CLINICAL SIGNS AND SYMPTOMS ASSOCIATED WITH A PREVIOUSLY DIAGNOSED

## CONDITION WHERE AN APPROPRIATE COURSE OF TREATMENT IS IN PROGRESS.

When a level of care for a public pay resident has changed as documented on the UAI, the assessor must immediately notify the financial eligibility worker of the date of the assessment. If there is a change in level of care, and the ALF is licensed for the new level, then the ALF would receive payment for the new level of care based on the effective date of authorization on the DMAS-96.

### 10. Reimbursement for a Change in Level of Care Assessment

In order to be reimbursed for an assessment for change in level of care, the assessor must send to DMAS the following:

- **DMAS-96.** On the DMAS-96, indicate the change in level of care determination as follows: #11 for residential living; #12 for regular assisted living. See the DMAS-96 for other options.
- **UAI**, short or long form as appropriate.

The assessment package is sent to:

First Health Services  
P.O. Box 85083  
Richmond, Virginia 23285-5083

#### 10.1 Notifications for Change in Level of Care

In addition to the above, the assessor must distribute the following information:

1. **To the LDSS Eligibility Worker**, the assessor must send a copy of the DMAS-96.
2. **To the ALF**, the assessor sends the original UAI and the DMAS-96.
3. **To the individual being assessed**, the assessor sends a decision letter.
4. **The assessor** keeps copies of the UAI, DMAS-96, and the decision letter.

If the ALF is licensed for assisted living, has a contract with DMAS, and the care need is authorized by an authorized assessor, then the ALF may receive payment as indicated. However, a change in level of care is only authorized by completing the UAI and a new DMAS-96. An assessment for a change in level of care is not conducted for temporary changes expected to last less than 30 days.

## **11. OUTCOMES OF ANNUAL REASSESSMENTS OR CHANGE IN LEVEL OF CARE**

The possible outcomes from these assessments may include:

- Continue at the current level of care;
- Change in the level of care;
- Transfer to another ALF at the appropriate level of care;
- Referral to a preadmission screening (PAS) team to review if the individual is appropriate for Medicaid-funded community-based care or nursing facility care (See Chapter II); or
- Referrals to other community resources (non-Medicaid-funded) such as home health services, adult day care centers, home-delivered meals, etc.

## **12. DISCHARGE FROM THE ALF**

The resident must be discharged from the ALF if a prohibited condition is revealed during the reassessment or a PAS team determines that the resident needs nursing facility level of care. The resident must also be discharged if he no longer meets the criteria for placement in the ALF or the ALF is not licensed for the level of care needed. All discharge procedures must be followed (see Chapter V).

## **13. REIMBURSEMENTS TO THE ASSESSOR FOR INITIAL ASSESSMENTS AND CHANGES IN LEVEL OF CARE**

Reimbursement for annual reassessments and changes in level of care will be based upon the submitted admission package information similar to the current PAS process. In order to receive reimbursement for assessments, the authorized assessor must have a signed DMAS provider agreement and provider number. The provider number must be noted on the DMAS-96 to indicate to whom the payment should be made. See Chapter VII for instructions on the reimbursement process.

## CHAPTER IV: PSYCHOSOCIAL ASSESSMENTS

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## **1. PSYCHOSOCIAL ASSESSMENTS**

The presence of cognitive problems and mental impairments can have an impact on the ability of an individual to live successfully in an ALF. Cognitive impairments can affect a person's memory, judgment, conceptual thinking and orientation. In turn, these can limit the ability to perform ADLs and IADLs. When assessing an individual for possible cognitive impairment, it is important to distinguish between normal minor losses in intellectual functioning and the more severe intellectual impairments caused by cognitive disorders such as Alzheimer's Disease or Organic Brain Syndrome (OBS). Some intellectual dysfunction may be caused by a physical disorder or by side effects or interactions of medications.

When determining the appropriateness of ALF admission for individuals with mental illness, mental retardation, or a history of substance abuse, a current psychiatric or psychological evaluation may be needed. The need for this evaluation will be indicated by the UAI and the completed "Indicators for Referral to the Department of Mental Health, Mental Retardation and Substance Abuse Services", found in Appendix K of the User's Manual: Virginia Uniform Assessment Instrument, July 2005. It could also be based upon the recommendation of the individual's case manager, other assessor or by the admission staff at the time of the admission interview. The evaluation must be completed by a person having no financial interest in the ALF, directly or indirectly as an owner, officer, employee, or as an independent contractor with the facility.

The assessor or case manager are not diagnosing the individual, but by using his professional judgment and the guidelines in the User's Manual: Virginia Uniform Assessment Instrument, are looking for indicators of the possible need for a referral to the local CSB, behavioral health authority (BHA) or other mental health professional for a more thorough mental health and/or substance abuse assessment and possible diagnosis. APPENDIX K provides a format to document the indicators that may necessitate mental health referrals. The assessor should refer such individuals to a mental health professional if there is any suspicion that the individual exhibits any of these indicators and if services are needed to meet the identified mental health issue.

**Appendix K should be included with the UAI when it is forwarded to the ALF which is considering the individual's admission.**

## **2. REFERRAL FOR MENTAL HEALTH, MENTAL RETARDATION, OR SUBSTANCE ABUSE EVALUATION**

One of the requirements of the VDSS Division of Licensing Programs for the admission or retention of a resident is:

**A SCREENING OF PSYCHOLOGICAL, BEHAVIORAL, AND EMOTIONAL FUNCTIONING, CONDUCTED BY A QUALIFIED MENTAL HEALTH PROFESSIONAL, IF**

RECOMMENDED BY THE UAI ASSESSOR, A HEALTH CARE PROFESSIONAL, OR THE ADMINISTRATOR OR DESIGNEE RESPONSIBLE FOR THE ADMISSION AND RETENTION DECISION. THIS INCLUDES MEETING THE REQUIREMENTS OF 22 VAC 40-72-360 (REGULATION 22 VAC 40-72-340).

If the UAI and the Appendix K documents mental health indicators, an evaluation completed within six months of the proposed admission date will generally be needed for consideration for the individual's admission.

Although it is the responsibility of the individual seeking admission to an ALF, his legal representative and the ALF admission staff to ensure that the evaluation is completed, the assessor or case manager will usually be involved in arranging for the evaluation.

If the ALF staff can provide adequate care, the individual may be admitted before the completion of his or her evaluation. In this situation, the decision to admit the individual without the completed evaluation must be documented in to the individual's record (see section 3.2).

Referrals for mental health/mental retardation/substance abuse evaluations should be made using the following guidelines:

## **2.1 Referral for Mental Illness Evaluation**

A referral for an mental illness (MI) evaluation is made for a diagnosis of schizophrenia, personality disorder, mood disorder, panic, somatoform disorder, other psychiatric disorders, paranoid disorder, or other serious anxiety disorders AND when the individual exhibits distorted thought processes, mood disorders, OR maladaptive behavior manifested by 1) acts detrimental to self or others; 2) acts of abuse, aggression, or disruption; or 3) emotional status which interferes with functioning ability (e.g., agitation, fearfulness, or depression).

## **2.2 Referral for Mental Retardation Evaluation**

A referral is made for a mental retardation evaluation if:

1. The individual has a condition of MR (IQ is 70-75 or below; age of onset is 18 years or below); there are significant limitations in two or more applicable adaptive skills areas such as communication, social skills, health and safety, work, self care, home living, community use, self-direction, functional academics, and leisure); OR
2. The individual has a suspected diagnosis of MR (received special education or did not complete school or has substantial functioning limitations in two or more of adaptive skills areas above); OR

3. The individual has a related condition (developmental disability) that is a severe, chronic disability attributable to mental and/or physical impairment that was manifested before age 22, is likely to continue indefinitely, and results in a substantial functional limitation in three or more major life activities such as self-care, receptive and/or expressive language, mobility, self-direction, and capacity for independent living or economic self-sufficiency.

### **2.3 Referral for Substance Abuse Evaluation**

A referral for evaluation should be considered for further exploration when the individual reports current drinking of more than two alcoholic drinks per day, has current use of non-prescription mood-altering substances such as marijuana, amphetamines, etc., and/or abuses prescribed mood-altering substances.

## **3. LICENSING REQUIREMENTS FOR SCREENING OF PSYCHOLOGICAL, BEHAVIORAL AND EMOTIONAL FUNCTIONING PRIOR TO ADMISSION**

### **3.1 MENTAL HEALTH SCREENING** (REGULATION 22 VAC 40-72-360)

A MENTAL HEALTH SCREENING SHALL BE CONDUCTED PRIOR TO ADMISSION IF BEHAVIORS OR PATTERNS OF BEHAVIOR OCCURRED WITHIN THE PREVIOUS SIX MONTHS THAT WERE INDICATIVE OF MENTAL ILLNESS, MENTAL RETARDATION, SUBSTANCE ABUSE OR BEHAVIORAL DISORDERS AND THAT CAUSED, OR CONTINUE TO CAUSE, CONCERN FOR THE HEALTH, SAFETY, OR WELFARE EITHER OF THAT INDIVIDUAL OR OTHERS WHO COULD BE PLACED AT RISK OF HARM BY THAT INDIVIDUAL.

**3.2 EXCEPTION:** IF IT IS NOT POSSIBLE FOR THE SCREENING TO BE CONDUCTED PRIOR TO ADMISSION, THE INDIVIDUAL MAY BE ADMITTED IF ALL OTHER ADMISSION REQUIREMENTS ARE MET. THE REASON FOR THE DELAY SHALL BE DOCUMENTED AND THE SCREENING SHALL BE CONDUCTED AS SOON AS POSSIBLE (SEE SECTION 4).

### **3.3 PSYCHOSOCIAL AND BEHAVIORAL HISTORY** (REGULATION 22 VAC 40-72-365)

WHEN DETERMINING APPROPRIATENESS OF ADMISSION FOR AN INDIVIDUAL WITH A MENTAL HEALTH DISABILITY, THE FOLLOWING INFORMATION SHALL BE OBTAINED BY THE FACILITY:

1. IF THE PROSPECTIVE RESIDENT IS REFERRED BY A STATE OR PRIVATE HOSPITAL, COMMUNITY SERVICES BOARD, BEHAVIORAL HEALTH AUTHORITY, OR LONG-TERM CARE FACILITY,

DOCUMENTATION OF THE INDIVIDUAL'S PSYCHOSOCIAL AND BEHAVIORAL FUNCTIONING SHALL BE ACQUIRED.

2. IF THE PROSPECTIVE RESIDENT IS COMING FROM A PRIVATE RESIDENCE, INFORMATION ABOUT THE INDIVIDUAL'S PSYCHOSOCIAL AND BEHAVIORAL FUNCTIONING SHALL BE GATHERED FROM PRIMARY SOURCES, SUCH AS FAMILY MEMBERS OR FRIENDS. THERE IS NO REQUIREMENT FOR WRITTEN INFORMATION FROM PRIMARY SOURCES.

THE ADMINISTRATOR OR HIS DESIGNEE SHALL DOCUMENT THAT THE INDIVIDUAL'S PSYCHOSOCIAL AND BEHAVIORAL HISTORY WERE REVIEWED AND USED TO HELP DETERMINE THE APPROPRIATENESS OF THE ADMISSION, AND IF THE PERSON IS ADMITTED, TO DEVELOP AN INDIVIDUALIZED SERVICE PLAN.

#### **4. MENTAL HEALTH DETERMINATION FORM**

The model "Mental Health Services Determination" form can be used to document the completion of individual's mental health screening. A copy of the form is available at: [http://www.dss.virginia.gov/facility/alf\\_forms.cgi](http://www.dss.virginia.gov/facility/alf_forms.cgi). The ALF may develop its own format but it must address the same information as on the model form. The "Mental Health Services Determination" form is also used to document the admission of an individual under the exemption in 22 VAC40-72-360.

The decision to admit an individual without a mental health evaluation must meet the following criteria and be documented in the individual's ALF record:

1. The facility's decision to admit the individual, without the pending assessment, is based on a careful consideration of any information regarding the prospective resident's emotional or behavioral functioning that could signal high risk concerns for the health and safety of the prospective resident and/or others;
2. The facility has developed a preliminary plan of care that appropriately addresses any identified concerns to a degree that the prospective resident is not considered high risk for harm to self and/or others;
3. The facility has been informed by the qualified mental health professional (QMHP) as to the expected date of completion of the mental health evaluation and the facility has determined that the length of time to have the evaluation completed and forwarded to the facility would cause hardship for the prospective resident and/or family;

4. The preliminary mental health assessment contained in Appendix K of the User's Manual: Virginia Uniform Assessment and the required collateral information were used as part of the information required to determine the appropriateness of admission;
5. The facility follows up with the disposition of the mental health evaluation and, upon receiving it, re-evaluates its ability to meet the needs of the resident regarding the mental health care/supervision that might be needed;
6. The facility clearly documents all efforts made to get the mental health evaluation completed; and
7. The facility meets all other admission requirements (e.g., completed UAI, and physical examination, and has no prohibitive conditions as described in Chapter II.

## **5. ASSESSMENT OF INDIVIDUALS RECEIVING STATE PLAN OPTION CASE MANAGEMENT SERVICES FOR MENTAL HEALTH OR MENTAL RETARDATION**

CLIENTS OF A COMMUNITY SERVICE BOARD MUST BE ASSESSED AND REASSESSED BY QUALIFIED ASSESSORS OF THE COMMUNITY SERVICE BOARD.

CSBs/BHAs must be involved in the assessment process for those clients already receiving Medicaid-funded state plan option (SPO) case management services for mental health or mental retardation. DMAS funds two separate services for AG residents of ALFs: the initial assessment and targeted case management services. Targeted case management also includes the annual reassessment. DMAS will not reimburse for targeted case management services for the same individual by more than one type of case management provider. Therefore, an individual may not receive mental health/mental retardation case management and targeted ALF case management services at the same time.

The following clarification is made for SPO clients:

- 5.1** Assessments (initial assessments and change in level of care assessment for current SPO case management clients):
  1. All ALF applicants and current residents who are receiving SPO mental health or mental retardation case management services must receive their initial assessment, using the UAI, from the CSB/BHA providing the case management services.
  2. ALF residents who are receiving SPO mental health or mental retardation case management services must receive change in level

of care assessments from the CSB/BHA providing case management services.

**5.2 ALF Case Management (Annual assessment and ongoing case management services for current SPO mental health or mental retardation case management clients):**

1. All residents of ALFs who are receiving SPO mental health or mental retardation case management services must receive their annual reassessment from the CSB/BHA providing the case management services. The CSB/BHA will not receive additional payment for this assessment because it is part of the SPO case management activities.
2. An individual can only receive one waiver service at a time.

**6. ADDITIONAL REQUIREMENTS FOR FACILITIES THAT CARE FOR ADULTS WITH SERIOUS COGNITIVE IMPAIRMENTS WHO CANNOT RECOGNIZE DANGER OR PROTECT THEIR OWN SAFETY AND WELFARE**

When determining the appropriateness of ALF admission, serious cognitive deficits should be noted on the UAI and Appendix K and communicated to the ALF. The ALF must determine if it can meet the needs of the resident.

All facilities that care for residents with serious cognitive impairments due to a primary psychiatric diagnosis of dementia who cannot recognize danger or protect their own safety and welfare are subject to additional licensing requirements.

These requirements include:

1. Additional staffing and staff training;
2. Security monitoring systems on the doors and windows;
3. A secured outdoor area or close staff supervision; and
4. Special environmental precautions.

These additional requirements do not apply to ALFs with 10 or fewer residents if no more than three of the residents have serious cognitive impairments who do not recognize danger or protect their own safety or welfare.

**6.1 Safe, Secure Environment**

Some ALFs may have one or more self-contained special care units in the facility or the whole facility may be a special care unit designed for those residents with serious cognitive impairments who cannot recognize danger or protect their own

safety and welfare. These special care units must meet all the additional licensing requirements and have additional admission procedures.

## **6.2 Assessment**

Prior to admission to a special care unit, the individual shall have been assessed by an independent clinical psychologist licensed to practice in the Commonwealth or by an independent physician. See Exhibit 2 for a copy of the Assessment of Serious Cognitive Impairment. A copy of the form can also be found at:

[http://www.dss.virginia.gov/facility/alf\\_forms.cgi](http://www.dss.virginia.gov/facility/alf_forms.cgi). The assessment must be in writing and address, but not limited to, the following areas:

1. Cognitive functions, e.g., orientation, comprehension, problem-solving, attention/concentration, memory, intelligence, abstract reasoning, judgment, insight;
2. Thought and perception, e.g., process, content;
3. Mood/affect;
4. Behavior/psychomotor;
5. Speech/language; and
6. Appearance.

## **6.3 Approval**

Prior to placing a resident in a special care unit, the ALF must obtain written approval from one of the following persons:

1. The resident, if capable of making an informed decision;
2. A guardian or other legal representative
3. A relative willing to act as the resident's representative in the following specific order:
  - a) Spouse,
  - b) Adult child,
  - c) Parent,
  - d) Adult sibling,
  - e) Adult grandchild,
  - f) Adult niece or nephew,
  - g) Aunt or uncle.
4. An independent physician, if the resident is not capable of making an informed decision and there is no one else available.

**EXHIBIT 1: APPENDIX K of the User's Manual: Virginia Uniform Assessment Instrument (July 2005)**

***INDICATORS FOR REFERRAL TO THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES***

You will obtain important direct and indirect information from other sections of the instrument which can be used to complete the mental health assessment. Pay particular attention to the following aspects of the individual's appearance and behavior during the total interview with the client and/or caregiver for pertinent information about a person's cognitive and emotional behavior.

**Demographic:** Can the client accurately give information about address, telephone number, date of birth, etc.?

**Physical Environment:** Is the living area cluttered, unclean, with spoiled food around, or numerous animals not well cared for? Is there evidence of pests?

**Appearance:** Does the client have soiled clothing and poor hygiene?

**Functional Status:** Does the client have difficulty with physical/maintenance of activities of daily living (ADLs)? Does a once routine activity now seem too complex to the client? (This may indicate dementia.) Does the client start an activity and then stop in the middle of it? Does the client walk with unsteady gait, have trouble with balance, and appear awkward? Does the client have slowed movements; everything seems an effort, tired, weak? Any of these may indicate depression or the need for further evaluation.

**IADLs:** Does the client have diminished or absent ability to do instrumental ADLs?

**Health Assessment:** Does the client have somatic concerns: complain of headaches, dizziness, shortness of breath, heart racing, faintness, and stomach or bowel disturbances (May indicate depression)? Does the client have trouble falling asleep awakening early or awakens for periods in the middle of the night? This may also indicate depression or the need for further evaluation.

**Medication:** Is there inappropriate use or misuse of prescribed and/or over-the-counter medications?

**Speech:** Are there speech difficulties, slurring, word-finding problems, can't get ideas across? (May indicate dementia).

**Fractures/Dislocations:** Does the client have fractures/bruises and is hesitant to give the cause?

**Nutrition:** Does the client have problems with appetite--eating too much or too little? Does the client have an unhealthy diet?

**Hospitalization/Alcohol Use:** Does the client have problematic alcohol use?

**Cognitive:** Does the client appear confused, bewildered, confabulates answers, speaks irrelevantly or bizarrely to the topic? Is the client easily distracted, has poor concentration, responds inconsistently when questioned? Is the client aware of surroundings, time, place, and situation? Does the client misplace/lose personal possessions? (May or may not complain of this) Does the client have angry outbursts and agitation? Does the client have decreased recognition of family and familiar places?

**Emotional/Social:** Does the client appear sad, blue, or despondent? Have crying spells, complains of feeling sad or blue, speaks and moves slowly, suffers significant appetite and sleep habit changes, has vague/somatic complaints and complains of memory impairments without objective impairment? (May indicate depression) Does the client appear unusually excited or emotionally high? Show pressured, incessant and rapid speech? Brag, talk of unrealistic plans, and show a decreased need for food or sleep? (May indicate grandiosity, euphoria, mania) Does the client appear to be hallucinatory? Hear or see things that aren't there? Talk, mutter, or mumble to himself/herself? Giggle or smile for no apparent reason? (May indicate hallucinations) Does the client appear to be suspicious, feel that others are against him/her? Out to get him/her? Feel others are stealing from him/her? Feel he/she is being persecuted or discriminated against? Believe has special qualities/power? (May indicate delusions) Does client feel life is not worth living? Has she/he given up on self/ Does individual feel those who care about him/her have given up on him/her? Has the client ever considered ending his/her life? (May indicate suicidal thoughts, ideation, or gestures) Has the client ever considered harming someone? (May indicate homicidal ideation) Is the client fidgety, nervous, sweating, fearful, pacing, agitated, frightened, and panicky? (May indicate fearfulness, anxiety, or agitation) Inappropriate and disturbing (disruptive) behavior, particularly when it is more problematic for caretakers than the client (take note of how often the behavior occurs, when it began, and how much it currently upsets people in the immediate environment):

- Being suspicious and accusatory
- Verbally threatening to harm self or others
- Yelling out, screaming, cursing
- Taking others' things, hiding/hoarding possessions
- Being agitated, uncooperative and resistive with necessary daily routines
- Being a danger to self or others

- Exhibiting inappropriate sexual behavior
- Inappropriately voiding of urine or feces (voiding in non-bathroom locations)
- Being unaware of need to use bathroom or problems locating a bathroom
- Exhibiting intrusive or dangerous wandering (danger of getting lost, entering/damaging others' property, wandering into traffic)
- Exhibiting poor impulse control
- Exhibiting impaired judgment

Based on your assessment, if the client is currently exhibiting any of the following, a referral to the local CSB/BHA or other mental health professional should be considered:

<b><u>Behavior</u></b>	<b><u>Thinking</u></b>	<b><u>Affective/Feelings</u></b>
Aggressive/combatative	Hallucinations	Helplessness
Destructive to self, others, or property	Delusions	Hopelessness
Withdrawn/social isolation	Disoriented	Feeling worthless
Belligerence/hostility	Seriously impaired judgment	Sadness
Anti-social behavior	Suicidal/homicidal thoughts, ideas, or gestures	Crying spells
Appetite disturbance	Cannot communicate basic needs	Depressed
Sleep disturbance	Unable to understand simple commands	Agitation
Problematic substance abuse	Suspicion/persecution	Anxiety
Sets fires	Memory loss	
	Grandiosity/euphoria	

If an individual is dangerous to self or others or is suicidal, an immediate call must be made to the local CSB/BHA or other mental health professional.

**Substance Abuse:** A referral to the CSB/BHA should be considered when:

- A client reports current drinking of more than 2 drinks of alcohol per day. Further exploration of the usage is suggested; or
- Any current use of non-prescription mood-altering substances (e.g., marijuana, amphetamines).

## **Mental Retardation/Developmental Disability**

### **Mental Retardation:**

Diagnosis if:

- The person's intellectual functioning is approximately 70 to 75 or below;
- There are related limitations in two or more applicable adaptive skills areas; and
- The age of onset is 18 or below.
- Use these questions or observations to assess undiagnosed but suspected MR:
- Did you go to school?
- What grade did you complete in school?
- Did you have special education?
- Does the individual have substantial functioning limitations in two or more of the following adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work?

If a person meets the above definition of mental retardation, a referral should be made to the local CSB/BHA.

### **Developmental Disability**

**Definition:** A severe, chronic disability of a person that:

- Is attributable to a mental or physical impairment or combination of mental or physical impairments;
- Is manifest before age 22;
- Is likely to continue indefinitely; and
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language; mobility; self-direction and capacity for independent living or economic self-sufficiency; or reflects the need for a combination and sequence of special interdisciplinary or generic care, treatment, or other services which are lifelong or extended duration and are individually planned and coordinated.

Developmental disability includes, but is not limited to, severe disabilities attributable to autism, cerebral palsy, epilepsy, spinal bifida, and other neurological impairment where the above criteria are met. People who have mental health, mental retardation, or substance abuse problems should be assisted to achieve the highest level of recovery, empowerment, and self-determination that is possible for them. In order to achieve this,

applications to and residents of facilities such as assisted living facilities may need mental health, mental retardation, or substance abuse services.

If a need for these services is identified, the client should be referred to the CSB/BHA, or other appropriate licensed provider that serves the locality in which the person resides. It is not necessary to make a diagnosis or to complete a clinical assessment to make a referral to a CSB/BHA/licensed provider, but it is important to describe the behavior and/or symptoms that are observed on the screening matrix.

## **SCREENING FOR MENTAL HEALTH/MENTAL RETARDATION/ SUBSTANCE ABUSE NEEDS**

Concerns/Symptoms/Behaviors	Refer to CSB/BHA or appropriate Licensed Provider for MH services	Refer to CSB/BHA or appropriate Licensed Provider for MR services	Refer to CSB/BHA or appropriate Licensed Provider for SA services	Refer 1 <sup>st</sup> to PCP for Medical Screening/ Services	Please record info. on most appropriate UAI sections noted below
1. Received a diagnosis of mental retardation, originating before the age of 18 years, characterized by significant sub-average intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning (IW test) that is at least two standard deviations below the mean and significant limitations in adaptive behavior as expressed in conceptual, social, and practical skills.					
2. Currently engaging in I.V. drug abuse and is willing to seek treatment.					
3. Currently pregnant and engaging in substance abuse to the degree that the health/welfare of the baby is seriously compromised, and is willing to seek treatment.					
4. Currently expressing thoughts about wanting to die or to harm self or others.					
5. Currently under the care of a psychiatrist and taking medications prescribed for serious mental health disorders (e.g. schizophrenia, bi-polarity, or major affective disorders.)					
6. Past history of psychiatric treatment (outpatient and/or hospitalizations) for serious mental health disorders (e.g. schizophrenia, bipolarity, or major affective disorders.)					
• Currently exhibiting the following behaviors that are not due to medical or organic causes:					
• Reports hearing voices, and/or talks to self, giggles/smiles at inappropriate times).					
• Reports seeing thing that are not present.					
• Inflicting harm on self by cutting, burning, etc.					
• Has difficulty staying physically immobile, insists on constantly moving physically within the environment, paces rapidly, and/or talks in a very rapid fashion, and may express grandiose and obsessive thoughts.					
• Confused, not oriented/aware of person, place, and time; may wander in or outside of facility/ home.					
• Significant mood changes occur rapidly within one day and are not related to the environment.					
• Becomes easily upset and agitated, exhibits behaviors others find intimidating, threatening, or provocative, may destroy property, and may feel others will "hurt" them.					
• Cries often, appears consistently sad, and exhibits very few other emotions.					
• Has little appetite or energy, consistently sleeps more than 9-10 hours /day, or has problems sleeping, and has little interest in social activities.					
• Level of personal hygiene and grooming has significantly declined.					
7. Displaying behaviors that are considered very unusual in the general population and a medical exam has found no physical basis (i.e. Alzheimer's Disease, brain injury, MR, etc.) Behaviors may include:					
• Eating non-food items					
• Voiding (urine and/or feces) in inappropriate places					

and/or inappropriately handling/disposing of these items.					
• Inappropriate sexual aggression or exploitation.					
• Combatively engaging in odd, ritualistic behaviors.					

## Exhibit 2: Assessment of Serious Cognitive Impairment

### **Standards and Regulations for Licensed Assisted Living Facilities requires:**

Prior to his admission to a safe, secure environment, a resident shall have been assessed by a clinical psychologist licensed to practice in the Commonwealth or by an independent physician as having a serious cognitive impairment due to a primary psychiatric diagnosis of dementia with an inability to recognize danger or protect his own safety and welfare. The physician making the assessment shall have an appropriate clinical background in the relevant area of serious cognitive impairments.

The regulation defines “serious cognitive impairment” as severe deficit in mental capability of a chronic, enduring or long term nature that affects areas such as thought processes, problem-solving, judgment, memory, and comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, and impulse control. Such cognitive impairment is not due to acute or episodic conditions, nor conditions arising from treatable metabolic or chemical imbalances or caused by reactions to medication or toxic substances.

**Name of Prospective Resident:** \_\_\_\_\_

**Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Address:** \_\_\_\_\_  
(Street)  
\_\_\_\_\_  
(City)  
\_\_\_\_\_  
(State/Zip Code)

**Cognitive Functions (Orientation, Comprehension, Problem-solving, Attention/Concentration, Memory, Intelligence, Abstract Reasoning, Judgment, Insight, Etc.):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thought and Perception (Process, Content):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Mood/Affect:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Prospective Resident: \_\_\_\_\_

Behavior/Psychomotor: \_\_\_\_\_

\_\_\_\_\_

Speech/Language: \_\_\_\_\_

\_\_\_\_\_

Appearance: \_\_\_\_\_

\_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

**DOES THE INDIVIDUAL NAMED ABOVE HAVE A SERIOUS COGNITIVE IMPAIRMENT DUE TO A PRIMARY PSYCHIATRIC DIAGNOSIS OF DEMENTIA WITH AN INABILITY TO RECOGNIZE DANGER OR PROTECT HIS/HER OWN SAFETY AND WELFARE?**

☐ YES      ☐ NO

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Licensed Physician or Virginia-Licensed Clinical Psychologist

\_\_\_\_\_  
(Please print or type physician's or psychologist's name here)

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

(Street)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State/Zip Code)

**Exhibit 3: Mental Health Screening Determination Form**  
(See 22 VAC 40-72 340, 360 and 365)

<b>Resident's Name:</b>	<b>Referred for Admission by:</b>
<b>Date Resident Interviewed for Admission:</b>	<b>Date Resident Admitted to this Facility:</b>
<b>Part I. Mental Health Screening</b>	
Date mental health screening was recommended for admission or retention, if applicable: _____	
Date mental health screening was completed for admission or Retention: _____	
Date mental health screening was reviewed by facility: _____	
1) Based on all sources of information gathered for determining the appropriateness of admission or retention, has a recommendation been made, if appropriate, to have the (prospective) resident referred to a qualified mental health professional (QMHP) to determine whether the person presents a risk of harm to self and/or others? [Circle one: Yes / No] If a recommendation for a screening was made but a referral was not done, explain:	
2) If a mental health screening was recommended but there will be a delay in having it completed and the results made available to the facility, explain the reason for the delay and the expected length of the delay.	
3) If a mental health screening was recommended and the results were made available to the facility, did the facility use the information to help determine whether the facility can meet or continue to meet the needs of the individual, such as equipping staff with specialized training, providing a higher level of supervision, offering psychosocial activities, or providing a type of physical environment that will enhance protection? [Circle one: Yes / No]	
4) If there are special considerations for the facility to help support meeting the mental health needs of the (prospective) resident, what are they?	
5) If a QMHP completed a mental health screening for a (prospective) resident and a recommendation for mental health services was made, have the resident, a mental health services provider, the authorized contact person, the physician of record, and, if applicable, the legal representative been notified? [Circle one: Yes / No] If not, explain:	
<b>Part II. Psychosocial and Behavioral History</b>	
1) If there are indications of mental health problems within the past six months, has the referring party provided a documented psychosocial and behavioral history that describes the prospective resident's psychological, social, emotional, and behavioral functioning (if the party is a family member, a significant other, or friend, the information may be obtained by interview and documented by the facility)? [Circle one: Yes / No]	

2) Did the facility consider the information contained in the psychosocial and behavioral history in making a decision about whether the facility can meet the needs of the individual? [Circle one: Yes / No] Date History Reviewed:	
3) Does the psychosocial and behavioral history indicate special considerations for the facility to help meet the mental health needs of the prospective resident [Circle one: Yes / No] If so, what are they?	
4) If the person is admitted, was the psychosocial and behavioral history used in the development of the individualized service plan? [Circle one: Yes / No]	
<b>Additional Comments Regarding Admission/Retention:</b>	
<b>Signature of Facility Administrator (or Designee):</b> _____	<b>Date:</b> _____

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## CHAPTER V: ADMISSION, DISCHARGE AND SPECIAL ASSESSMENT FACTORS

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## **1. ADMISSION TO AN ASSISTED LIVING FACILITY**

THE ASSISTED LIVING FACILITY MUST BE KNOWLEDGEABLE OF THE CRITERIA FOR LEVEL OF CARE IN AN ASSISTED LIVING FACILITY AND IS RESPONSIBLE FOR DISCHARGE OF THE RESIDENT WHENEVER A RESIDENT DOES NOT MEET THE CRITERIA FOR LEVEL OF CARE IN AN ASSISTED LIVING FACILITY UPON ADMISSION OR AT ANY LATER TIME.

Prior to placement in an ALF, the assessor should contact the ALF to discuss the level of care needed and to ensure that the ALF has the appropriate licensing and has a valid contract with DMAS if assisted living services are needed. The assessor must also discuss with the ALF staff the types of services needed by the applicant and determine whether the ALF is capable of providing the required services or that they are available in the community.

Once the placement is finalized, the assessor must notify the financial eligibility worker responsible for determining the AG payment of the effective date of admission using the DMAS-96. It is the assessor's responsibility to ensure that the required annual reassessments are completed. If the assessor is unable to complete the required annual reassessment or change in level of care assessments, the assessor must contact and arrange for another qualified assessor to complete the annual reassessment and change in level of care assessments.

### **1.1 Physical Examination**

VDSS Division of Licensing Programs regulations require that all individuals admitted to an ALF have a physical examination completed prior to the admission. VDSS Division of Licensing Programs has prepared a model form, "Report of the Physical Examination," which may be used for the physical examination. A copy of the form is available at: [http://www.dss.virginia.gov/facility/alf\\_forms.cgi](http://www.dss.virginia.gov/facility/alf_forms.cgi).

The use of this form is not required; any physical examination form that addresses all of the requirements is acceptable (i.e., includes tuberculosis status, etc.). A physician must sign the physical examination report.

It is the responsibility of the ALF, not the assessor, to ensure that the physical examination is completed. However, the assessor, social worker, or case manager may need to assist the applicant in obtaining the physical examination in order to facilitate the admission process.

If the same person completes both the UAI and the physical examination report, it is not necessary to repeat the same information on the physical examination that is also on the UAI. The assessor may make reference to the UAI (e.g., "see UAI") only for that information needed on the physical examination report that is the

same as the information provided on the UAI. All other parts of the physical examination report must be completed.

## **1.2 Home Health Care in the ALF**

When care of a resident's special medical needs is provided by licensed staff of a home care agency, the ALF staff may receive training from the home care agency staff in appropriate treatment monitoring techniques regarding safety precautions and actions to take in case of emergency. If a public pay resident has special needs that can be provided by a home health agency, DMAS may reimburse for these services after a review to determine if the services fall within DMAS' guidelines for home health services. Public pay recipients with one of the prohibited conditions cannot remain in an ALF, and DMAS will not reimburse for home health services in this case and may retract payment for services that have already been rendered.

## **1.3 Hospice Care in the ALF**

Notwithstanding the *Code of Virginia*, § 63.2-1805 (the section that includes prohibited conditions), at the request of the resident, hospice care may be provided in an ALF if the hospice program determines that such program is appropriate for the resident.

# **2. EMERGENCY PLACEMENTS IN AN ASSISTED LIVING FACILITY**

IN EMERGENCY PLACEMENTS, THE UNIFORM ASSESSMENT INSTRUMENT MUST BE COMPLETED WITHIN SEVEN WORKING DAYS FROM THE DATE OF PLACEMENT. AN EMERGENCY PLACEMENT SHALL OCCUR ONLY WHEN THE EMERGENCY IS DOCUMENTED AND APPROVED BY A VIRGINIA ADULT PROTECTIVE SERVICES WORKER FOR PUBLIC PAY INDIVIDUALS OR BY A VIRGINIA ADULT PROTECTIVE SERVICES WORKER OR INDEPENDENT PHYSICIAN FOR PRIVATE PAY INDIVIDUALS.

An emergency is a situation in which an adult is living in conditions that present a clear and substantial risk of death or immediate and serious physical harm to self or others. In emergency placements, all assessment and documentation requirements must be completed through a face to face contact within seven working days from date of placement. Typically, an emergency placement will involve an adult who lives outside of an institution and not already in an ALF.

The need for an emergency placement must be determined and approved by a Virginia adult protective services (APS) worker for public pay individuals and documented in the records of the APS worker. For private pay individuals, a Virginia APS worker or an independent physician may approve the emergency placement.

Prior to the emergency placement, the APS worker must discuss with the ALF the individual's service/care needs based on the APS investigation and assessment to ensure that the ALF is capable of providing the needed services. The individual cannot be admitted to an ALF on an emergency basis if the individual has any of prohibited conditions (see Chapter II).

This is the **only** instance in which an individual may be placed in an ALF without first having been assessed to determine if he or she meets ALF level of care. When an emergency placement is made, the UAI and the DMAS-96 must be completed within seven working days from the date of the placement. There must be documentation in the resident's record at the ALF that a Virginia APS worker approved the emergency placement. A notation on the UAI signed by the APS worker will meet this requirement. The assessment must be completed by a qualified assessor in the jurisdiction where the individual lived prior to the emergency placement.

In the case of an emergency placement, the assisted living authorization is considered effective as of the date of the emergency placement, provided that the Medicaid-Funded Long-Term Care Services Authorization (DMAS-96) is signed and dated within seven working days after the date of the emergency placement.

The DMAS and VDSS will monitor the approval of emergency placements and have the right to deny or overturn any decision made for emergency placement. Emergency placements are to be used only when a true emergency can be documented and justified.

### **3. OUT-OF-STATE INDIVIDUALS**

Individuals who reside out-of-state and wish admission to Virginia ALFs must be assessed and authorized prior to public reimbursement for these services. The local department of social services in the locality of the ALF accepts the AG application for out-of-state individuals who seek admission to a Virginia ALF. If an out-of-state applicant is clearly private pay, the admitting ALF is responsible for the assessment. If the individual is likely to be eligible for an AG, the public human services assessor completes the assessment prior to the individual's admission. Information may be obtained by telephone interview if a face-to-face interview is not practicable, with a follow-up on-site visit after the admission.

### **4. GENERAL RELIEF RECIPIENTS**

Unlike AG recipients, General Relief (GR) recipients are not Medicaid eligible. Regulation defines private pay individuals as those who are not AG recipients. All others are considered to be private pay. Payment for assisted living services for GR recipients in public ALFs, (i.e., district homes) is allowed. The assessment of these GR recipients can be treated like AG recipients in that DMAS will reimburse a public assessor \$25 for a short assessment and \$100 for a full assessment.

## **5. CHANGES IN FINANCIAL ELIGIBILITY STATUS OF AN ASSISTED LIVING FACILITY RESIDENT**

### **5.1 When a Private Pay Resident Needs to Apply for an Auxiliary Grant Recipient**

When a private pay resident of an ALF needs to apply for an AG, the LDSS eligibility worker will advise the resident of program requirements that include the need for an assessment. The AG eligibility determination is the responsibility of the local department of social services in the jurisdiction where the resident lived prior to admission to a facility. All assessment procedures must be followed. The public human services agency providing the assessment will be reimbursed at the initial assessment rate for the appropriate assessment. If an individual has had a private pay UAI completed, and he or she becomes eligible for an AG, a public pay UAI must be completed in order for services to be authorized.

The LDSS eligibility worker will advise the applicant as to which local department of social services to go to for the AG eligibility determination and discuss the qualified assessors available to conduct an assessment using the public pay UAI. The eligibility worker of appropriate jurisdiction must be provided with a copy of the Medicaid-Funded Long-Term Care Services Authorization (DMAS-96) for verification of the assessment. If there is a full UAI on record (not the two-paged private pay version) that is less than twelve months old, the resident does not need to be reassessed unless there is indication that his level of care has changed.

### **5.2 When an AG Recipient Becomes a Private Pay Resident**

If the resident becomes ineligible for an AG based on income or countable resources, the LDSS eligibility worker will issue a notice of adverse action to the recipient eleven days in advance of the action to terminate the AG. The ALF and the resident must determine whether the individual shall continue to reside in the ALF. If there were an ongoing case manager, the case manager would participate in the discharge planning process (see section 13), if appropriate, and then terminate case management services. If the resident continues to reside in the ALF as a private pay resident, assessment requirements for private pay residents must be followed.

## **6. MENTAL HEALTH/MENTAL RETARDATION FACILITY INPATIENTS**

Individuals who are patients in state mental health and mental retardation facilities and who seek ALF placement directly from these facilities must be assessed as an element in the required discharge plan (*Code of Virginia*, § 37.2-505). Qualified staff of the state facility will complete these assessments. Some state facilities discharge their individuals to

ALFs for “trial visits” (*Code of Virginia*, § 37.2-837) to ensure that the placement is appropriate. These clients must also be assessed using the UAI prior to the initial admission to the ALF.

## **7. VETERANS ADMINISTRATION MEDICAL CENTERS**

Individuals in Veterans Administration Medical Centers (VAMC) who are public pay individuals and who are applying to enter an ALF can be assessed by a qualified assessor from a public human services agency in the locality in which the facility is situated or by a physician of the hospital if he is enrolled as a DMAS provider to assess ALF applicants and residents. The physician may designate qualified staff to complete the assessment; however, he or she must sign and approve the assessment.

## **8. CORRECTIONAL SYSTEM INMATES**

The responsibility for ALF assessments of adults leaving the correctional system lies with the qualified assessors in the locality of the prison facility; this may include trained assessors in Community Release Units of the Department of Corrections. The correctional staff assessors must have completed the Virginia Uniform Assessment Instrument (UAI) course offered by an approved entity. A certificate of successful completion of the course must be placed in the assessor’s personnel file. The correctional facility will not receive reimbursement from DMAS for conducting the ALF assessment. If a non-correctional facility assessor performs the assessment, the assessor is advised to contact the correctional facility prior to the assessment to get a sense of whether the adult meets nursing facility or ALF criteria. If the adult is determined to require nursing facility care, then the assessor must contact the local preadmission screening team for a nursing facility screening.

## **9. RESPITE CARE**

Individuals admitted to an ALF for respite care must be assessed prior to admission. Respite care is a temporary stay in the facility, usually to relieve caregivers from their duties for a brief period of time. The initial assessment is valid for 12 months if the level of care of the individual remains the same. A reassessment would be required annually provided that the respite care continues to be provided, even if it is provided intermittently. Individuals receiving an AG are typically not admitted to an ALF for respite care.

## **10. ASSESSMENT OF PRIVATE PAY RESIDENTS**

FOR PRIVATE PAY INDIVIDUALS, QUALIFIED STAFF OF THE ASSISTED LIVING FACILITY OR AN INDEPENDENT PRIVATE PHYSICIAN MAY COMPLETE THE UNIFORM ASSESSMENT INSTRUMENT FOR. QUALIFIED STAFF OF THE ASSISTED LIVING FACILITY ARE EMPLOYEES OF THE FACILITY WHO HAVE SUCCESSFULLY

## COMPLETED STATE-APPROVED TRAINING ON THE UNIFORM ASSESSMENT INSTRUMENT FOR EITHER PUBLIC OR PRIVATE PAY ASSESSMENTS.

An alternate two-paged (front and back) assessment form has been developed for private pay (i.e. non-AG) residents. The Private pay form is available at:

<http://www.dss.virginia.gov/family/as/forms.cgi>. On this form, only information relevant to documenting level of care is collected. The common definitions that were developed for the UAI are also used for the private pay UAI. For additional information, refer to the *User's Manual: Virginia Uniform Assessment Instrument (UAI) for Private Pay Residents of Assisted Living Facilities*. The manual is available at: [http://www.dss.virginia.gov/family/as/uai\\_manual.cgi](http://www.dss.virginia.gov/family/as/uai_manual.cgi).

Individuals desiring to be qualified as assessors for private pay individuals in an ALF must have completed the Virginia Uniform Assessment Instrument (UAI) course offered by an approved entity such as the Virginia Institute for Social Services Activities (VISSTA) at Virginia Commonwealth University. VISSTA offers a web-based course on the completion of the private pay UAI that may be completed at an individual's convenience. A certificate of completion is automatically generated upon successful completion of the on-line course. For more information, please go to <http://www.vcu.edu/vissta/>. A certificate of successful completion of the course must be placed in the individual's personnel file.

A PRIVATE PAY INDIVIDUAL MAY REQUEST THE ASSESSMENT BE COMPLETED BY A QUALIFIED PUBLIC HUMAN SERVICES AGENCY ASSESSOR. WHEN A PUBLIC HUMAN SERVICES AGENCY ASSESSOR COMPLETES THE UNIFORM ASSESSMENT INSTRUMENT FOR A PRIVATE PAY INDIVIDUAL, THE AGENCY MAY DETERMINE AND CHARGE A FEE FOR PRIVATE PAY APPLICANTS AND RESIDENTS; THE FEE MAY NOT EXCEED THE FEE PAID BY DMAS FOR PUBLIC PAY APPLICANTS AND RESIDENTS.

### **11. INDIVIDUALS ASSESSED AND AWAITING ALF PLACEMENT**

At times, an individual who has been assessed as appropriate for ALF care has to remain in the community while waiting for an ALF placement. Once a placement becomes available, and if no more than 90 days have elapsed, a new assessment does not have to be completed unless there has been a significant change in the individual's condition. If more than 90 days have elapsed since the assessment was conducted, then a new assessment must be completed.

### **12. TRANSFER OF AN ALF RESIDENT**

#### **12.1 ALF-TO-ALF TRANSFER**

WHEN A RESIDENT MOVES TO AN ASSISTED LIVING FACILITY FROM ANOTHER ASSISTED LIVING FACILITY A NEW UNIFORM ASSESSMENT

INSTRUMENT IS NOT REQUIRED EXCEPT THAT A NEW UNIFORM ASSESSMENT INSTRUMENT SHALL BE COMPLETED WHENEVER THERE IS A SIGNIFICANT CHANGE IN THE RESIDENT'S CONDITION OR THE ASSESSMENT WAS COMPLETED MORE THAN 12 MONTHS AGO.

Individuals residing in an ALF and desiring a transfer to another ALF in the Commonwealth of Virginia are not required to be reassessed at the time of the transfer unless there has been a significant change in the resident's condition that would warrant a change in level of care or if the current assessment is more than twelve months old. The ALF from which the individual is transferring must send a copy of all current assessment material to the receiving facility. The requirements for discharge notifications must be followed. If the transfer is outside the jurisdiction of the transferring ALF, the ALF must arrange for an assessor in the new jurisdiction as part of the discharge plan. The receiving ALF is then responsible to initiate the appropriate documentation for admission purposes

## **12.2 ALF-TO-HOSPITAL TRANSFER**

Screening Teams in hospitals do not complete an assessment for individuals who are admitted to a hospital from an ALF when the individual is to be discharged back to either the same or a different ALF and the individual continues to meet the same ALF level of care or is expected to meet the same criteria for level of care within 30 days of discharge. In the event that the individual's bed has not been held at the ALF from which the individual left prior to being hospitalized, the individual would still not need to be evaluated by the hospital staff provided that he or she is admitted to another ALF at the same level of care. The hospital may, however, elect to perform the assessment, but is not required to do so.

If an individual is admitted to a hospital from an ALF and the individual's condition has not changed, but placement in a different ALF is sought, a new assessment is NOT required. The second ALF would be required to complete necessary documentation for admission. The first ALF must provide the required discharge notifications.

If there has been a change in level of care since the individual's admission to the hospital, the hospital assessors could perform a change in level of care assessment (see Chapter III), unless the change is anticipated to be temporary (i.e., expected to last less than 30 days).

If an individual is admitted to the hospital from an ALF and the individual needs to transfer to Medicaid-funded community-based care or nursing facility, a nursing home preadmission screening must be completed.

### **13. DISCHARGE FROM AN ALF**

DISCHARGE IS THE PROCESS THAT ENDS THE STAY IN AN ASSISTED LIVING FACILITY. STAFF OF THE ASSISTED LIVING FACILITY MUST PLAN FOR POST-DISCHARGE SERVICES WHEN THE PUBLIC PAY RESIDENT IS RETURNED TO A HOME-BASED PLACEMENT OR , A NURSING FACILITY, OR OTHER PLACEMENT. ASSISTED LIVING FACILITY STAFF SHALL NOTIFY IN WRITING THE LOCAL DEPARTMENT OF SOCIAL SERVICES FINANCIAL ELIGIBILITY WORKER IN THE JURISDICTION RESPONSIBLE FOR AUTHORIZING THE AUXILIARY GRANT AND THE PUBLIC HUMAN SERVICES AGENCY ASSESSOR OF THE DATE AND PLACE OF DISCHARGE AS WELL AS WHEN A RESIDENT DIES. THE ASSISTED LIVING FACILITY MUST MAKE THESE NOTIFICATIONS 14 DAYS PRIOR TO THE RESIDENT'S PLANNED DISCHARGE OR WITHIN FIVE DAYS AFTER THE DEATH OF THE RESIDENT. IN THE EVENT OF AN EMERGENCY DISCHARGE AS DEFINED BY 22 VAC 40-71-160, THE NOTIFICATION SHALL BE MADE AS RAPIDLY AS POSSIBLE, BUT MUST BE MADE BY CLOSE OF BUSINESS ON THE DAY FOLLOWING THE EMERGENCY DISCHARGE.

When a resident moves to an ALF from another ALF, a new UAI is not required except that a new or updated UAI must be completed whenever there is a change in the resident's condition that appears to warrant a change in the resident's approved level of care or the 12-month reassessment is due within 30 days of the transfer. The original ALF should forward a copy of the current assessment material to the new ALF. An updated UAI is required:

1. For the movement of a resident from one ALF to another ALF when there is a change in level of care; or
2. For the movement of an ALF resident to a nursing facility or Medicaid community-based waiver program (e.g., the Elderly and Disabled with Consumer Direction Waiver). The updated UAI must be forwarded to the health department on the local preadmission screening committee where the ALF is located for review and authorization of services. Placement authorization is documented by sending a completed DMAS-96 to the local department of social services of jurisdiction.

#### **13.1 DISCHARGE TO THE COMMUNITY**

When an ALF resident moves back to the community without Medicaid community-based services, an updated copy of the UAI may be forwarded to the local service provider if requested by the resident or his representative. All required discharge procedures must be followed.

## **13.2. DISCHARGE TO A NURSING FACILITY**

The Preadmission Screening (PAS) Committee in the locality of the ALF is responsible for the assessment and authorization of individuals who are ALF residents and who need nursing facility services. The ALF must schedule with the PAS Committee to complete a screening for the individual. The PAS committee handles this referral like any other referral coming from anywhere else in the community.

## **13.3 DISCHARGE TO MEDICAID COMMUNITY-BASED CARE**

The PAS Committee in the locality of the ALF is responsible for assessment and authorization for individuals who are ALF residents and who could possibly return to the community with the assistance of Medicaid-funded community-based care services. The ALF will schedule with the PAS Committee to complete a screening for any individual who wishes to be discharged home with Medicaid community-based care. The PAS Committee handles this referral as it would a referral coming from anywhere else in the community.

## **14. SUSPENSION OF LICENSE OR CLOSURE OF AN ASSISTED LIVING FACILITY**

UPON ISSUING A NOTICE OF SUMMARY ORDER OF SUSPENSION TO AN ASSISTED LIVING FACILITY, THE COMMISSIONER OF THE VIRGINIA DEPARTMENT OF SOCIAL SERVICES OR HIS DESIGNEE SHALL CONTACT THE APPROPRIATE LOCAL DEPARTMENT OF SOCIAL SERVICES TO DEVELOP A RELOCATION PLAN. THE RESIDENTS OF AN ASSISTED LIVING FACILITY WHOSE LICENSE HAS BEEN SUMMARILY SUSPENDED PURSUANT TO § 63.2-1709 OF THE CODE OF VIRGINIA SHALL BE RELOCATED AS SOON AS POSSIBLE TO REDUCE THE RISK OF JEOPARDIZING THE HEALTH, SAFETY, AND WELFARE OF RESIDENTS. AN ASSESSMENT OF THE RELOCATED RESIDENT IS NOT REQUIRED, PURSUANT TO 22 VAC 40-745-30 C 3

The ALF Relocation Plan is available to local department of social services staff at the Department's local agency intranet site in the Adult Service web site "AS documents." In the event that the local department receives advanced notification of such suspension of an ALF's licensure or plans for closure, the local department should immediately contact the appropriate regional AS/APS specialist to begin planning for the event.

## CHAPTER VI: ONGOING TARGETED CASE MANAGEMENT

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## 1. INTRODUCTION

Case management services include assessment, service location, coordination and monitoring for aged, blind and disabled individuals who are applying for or receiving an Auxiliary Grant (AG) to pay the cost of residential or assisted living care in a licensed assisted living facility (ALF) in order to facilitate access to and receipt of the most appropriate placement. In addition, the case management services will provide for periodic reassessment to determine whether the placement continues to meet the needs of the recipient of AG and to arrange for transfer to a more appropriate placement or arrange for supplemental services as the needs of the individual change.

The purposes of Medicaid-funded ALF case management are:

1. To assure the appropriate placement of individuals in ALFs.
2. To assure that appropriate payment is made to the ALFs.
3. To provide basic monitoring of the continued appropriate placement of residents and payment for their care in an ALF.

There are two types of Medicaid-funded case management services for ALF residents:

1. Annual reassessment only; or
2. Ongoing targeted ALF case management.

## 2. ANNUAL REASSESSMENT

The purpose of the annual reassessment is the reevaluation of service need and utilization review. The assessor or case manager shall review each resident's need for services annually, or more frequently as required, to ensure proper utilization of services. See Chapter III for further information on the annual reassessment.

**If a resident is receiving targeted case management services for mental illness or mental retardation, the agency case manager for this service must complete the reassessment and change in level of care assessment as part of case management responsibilities for that individual.** DMAS will not reimburse the case management agency for the completion of these assessments since they are a function of the case management procedures. The mental health case manager must complete the reassessment and follow the procedures for an annual reassessment. DMAS will not reimburse for the duplicate provision of case management services.

## 3. ONGOING MEDICAID-FUNDED TARGETED ALF CASE MANAGEMENT SERVICES

TARGETED CASE MANAGEMENT SHALL BE LIMITED TO THOSE RESIDENTS WHO HAVE MULTIPLE NEEDS ACROSS MULTIPLE PROVIDERS AND THIS

COORDINATION IS BEYOND THE SCOPE OF THE ASSISTED LIVING FACILITY. IT SHALL BE THE RESPONSIBILITY OF THE ASSESSOR WHO IDENTIFIES THE INDIVIDUAL'S NEED FOR RESIDENTIAL CARE OR ASSISTED LIVING CARE IN AN ASSISTED LIVING FACILITY TO ASSESS THE NEED FOR TARGETED CASE MANAGEMENT SERVICES AS DEFINED IN PART IV (12 VAC 30-50-470 ET SEQ.) OF 12 VAC 30-50.

Ongoing Medicaid-funded targeted ALF case management is a service provided to those public pay (AG) clients who are receiving residential or assisted living services and are not receiving targeted case management for mental health or mental retardation. These residents:

1. Require coordination of multiple services and/or have some problem which must be addressed to ensure the resident's health and welfare; and
2. Are not able and do not have other support available to assist in coordination of and access to services or problem resolution; and
3. Need a level of coordination that is beyond what the ALF can reasonably be expected to provide.

The assessor should check "yes" on the DMAS-96 for ALF targeted case management ONLY when the individual is determined to need Medicaid-funded ongoing targeted case management services that have been specifically developed for individuals residing in an ALF. "No" should be checked if the individual will receive only the annual reassessment or may be receiving other types of Medicaid-funded case management services.

The assessor must authorize and arrange for case management services through a qualified case manager if such services are determined to be needed. It is the responsibility of the ALF to determine whether or not the facility is capable of providing the required coordination of services. Prior to the ALF placement, the assessor must determine whether the ALF can meet the care needs and whether ongoing case management is needed. The assessor must communicate with the ALF to identify service needs and to ensure that service needs can be met. Based upon information obtained, the assessor should authorize case management services if the ALF cannot provide or arrange all the services needed by the potential resident. The individual selects a case management agency of his choice in the area where he will reside. The assessor must be aware of available Medicaid-funded ALF targeted case management agencies and assist the individual in his selection.

For AG recipients, a case management agency must have signed an agreement with DMAS to be reimbursed for the provision of targeted case management services.

The case manager identifies care needs and assists in locating and arranging for services that are beyond the scope of the ALF services. The individual chooses from the options

made available by the case manager, and the case manager facilitates accessing the service provider. DMAS has the right to terminate the contract for assessment and case management for failure to follow DMAS requirements.

Ongoing targeted ALF case management must be terminated when the resident no longer requires these services.

#### **4. PROVIDER AGREEMENT**

A CASE MANAGEMENT AGENCY MUST HAVE SIGNED AN AGREEMENT WITH DMAS TO BE REIMBURSED FOR THE PROVISION OF TARGETED CASE MANAGEMENT SERVICES TO AUXILIARY GRANT RECIPIENTS.

For private pay residents, fees are negotiated between the case manager and the resident.

#### **5. WHO CAN PROVIDE MEDICAID-FUNDED ALF CASE MANAGEMENT?**

Medicaid-funded case management services (either the annual reassessment or targeted ongoing case management) for ALF residents can be provided by staff of the following agencies who meet the knowledge, skills, and abilities (KSAs) of a case manager:

1. Local departments of social services;
2. Area agencies on aging;
3. Centers for independent living;
4. Community services boards;
5. Local departments of health; and
6. Private physicians who have a contract with DMAS to conduct assessments and who wish to follow clients on a continuing basis. Physicians who conduct assessments or reassessments or perform Medicaid-funded targeted case management may not have financial ties with the ALF.

THE LOCAL DEPARTMENT OF SOCIAL SERVICES WHERE THE ADULT RESIDES, FOLLOWING PLACEMENT IN AN ASSISTED LIVING FACILITY, SHALL BE THE CASE MANAGEMENT AGENCY WHEN THERE IS NO OTHER QUALIFIED CASE MANAGEMENT PROVIDER WILLING OR ABLE TO PROVIDE CASE MANAGEMENT SERVICES.

#### **6. WHO CANNOT PROVIDE MEDICAID-FUNDED ALF CASE MANAGEMENT?**

Acute care hospitals, state mental health/mental retardation facilities, and correctional facilities may not complete the 12-month reassessment or provide Medicaid-funded targeted ALF case management. These groups may perform the initial assessments.

## **7. QUALIFICATIONS OF CASE MANAGEMENT PROVIDERS**

A QUALIFIED CASE MANAGER MUST POSSESS A COMBINATION OF RELEVANT WORK EXPERIENCE IN HUMAN SERVICES OR HEALTH CARE AND RELEVANT EDUCATION WHICH INDICATES THAT THE INDIVIDUAL POSSESSES THE KNOWLEDGE, SKILLS, AND ABILITIES AT ENTRY LEVEL AS DEFINED IN PART IV (12 VAC 30-50-470 ET SEQ.) OF 12 VAC 30-50. THIS MUST BE DOCUMENTED ON THE CASE MANAGER'S JOB APPLICATION FORM OR SUPPORTING DOCUMENTATION OR OBSERVABLE IN THE JOB OR PROMOTION INTERVIEW. WHEN THE PROVIDER AGENCY IS A LOCAL DEPARTMENT OF SOCIAL SERVICES, CASE MANAGERS SHALL MEET THE QUALIFICATIONS FOR SOCIAL WORK/SOCIAL WORK SUPERVISOR CLASSIFICATION AS SPECIFIED IN 22 VAC 40-670.

A qualified case manager must demonstrate:

### **7.1 Knowledge:**

- (1) Aging;
- (2) The impact of disabilities and illnesses on elderly and non-elderly persons;
- (3) Conducting client assessments (including psychosocial, health and functional factors) and their uses in care planning;
- (4) Interviewing techniques;
- (5) Consumers' rights;
- (6) Local human and health service delivery systems, including support services and public benefits eligibility requirements;
- (7) The principles of human behavior and interpersonal relationships;
- (8) Effective oral, written, and interpersonal communication principles and techniques;
- (9) General principles of record documentation; and
- (10) Service planning process and the major components of a service plan.

### **7.2 Skills:**

- (1) Negotiating with consumers and service providers;

- (2) Observing, recording and reporting behaviors;
- (3) Identifying and documenting a consumer's needs for resources, services and other assistance;
- (4) Identifying services within the established services system to meet the consumer's needs;
- (5) Coordinating the provision of services by diverse public and private providers; and
- (6) Analyzing and planning for the service needs of elderly or disabled persons.

### **7.3 Abilities:**

- (1) Demonstrate a positive regard for consumers and their families;
- (2) Be persistent and remain objective;
- (3) Work as a team member, maintaining effective inter- and intra-agency working relationships;
- (4) Work independently, performing position duties under general supervision;
- (5) Communicate effectively, verbally and in writing;
- (6) Develop a rapport and communicate with different types of persons from diverse cultural backgrounds; and
- (7) Interview.

Individuals meeting all the above qualifications shall be considered a qualified case manager; however, it is preferred that the case manager possess a minimum of an undergraduate degree in a human services field, or be a licensed nurse. In addition, it is preferable that the case manager have at least two years of experience in the human services field working with the aged or disabled.

## **8. CASE MANAGER RESPONSIBILITIES**

The case manager for ongoing targeted ALF case management is responsible for:

1. The completion of the UAI, either short assessment or full assessment, as appropriate (the annual reassessment is considered one of the quarterly contacts; no additional reimbursement for reassessment beyond the quarterly reimbursement for case management will be made);
2. Any change in level of care, as appropriate;
3. Developing the plan of care that addresses needs on the UAI and maintaining the log of contacts and providing a copy of the care plan to the resident, the family, and the ALF. (See Appendix C for instructions and forms);
4. Implementing and monitoring the plan of care, including arranging, coordinating, and monitoring services;
5. Monitoring the ALF's Individualized Service Plan (ISP) for the resident and other written communications concerning the care needs of the resident;
6. A quarterly visit with the resident or his or her representative to evaluate the resident's condition, service needs, appropriate service placement and satisfaction with care;
7. Serving as the contact for the ALF, family, and other service providers to coordinate and problem solve; and
8. Assistance with discharge, as necessary.

## **9. THE PLAN OF CARE**

For purposes of Medicaid-funded ongoing targeted ALF case management, the plan of care (see Appendix C) is a standardized written description of the need(s) of the resident which cannot be met by the ALF and the case manager's strategy for arranging services to meet that need(s). The completion of the plan of care must include input from the individual, the family, and the ALF staff. The case manager determines which services must be provided to assure that the individual's health, safety, and welfare are protected.

The Plan of Care is different from the ISP. The ISP is the plan developed by the ALF staff that addresses the resident's needs and is required by VDSS Division of Licensing Programs standards. While different, the two should complement each other. The UAI Plan of Care addresses needs that cannot be met by the ALF.

The UAI Plan of Care is the form to be used by case managers authorizing ongoing case management services. The plan of care must be completed according to the type of service(s) being provided and must be resident-specific. When Medicaid-funded targeted case management services are provided, the case manager must follow DMAS guidelines

for preparing and implementing the care plan. The DMAS manual, “Assisted Living Services”, is available at: [http://165.176.249.159/prm-provider\\_manuals.htm](http://165.176.249.159/prm-provider_manuals.htm).

Once the case manager has determined the individual's needs, the support available to meet those needs, and any other special considerations or concerns, the case manager determines which services are available through the ALF and which needed services are available from community providers in order to ensure a successful ALF placement. Either the case manager or the individual would contact the community provider(s), chosen by the individual, to arrange and coordinate the provision of services. Under no circumstances should the provider receive a referral from the case manager for an individual unless the case manager has confirmed that the provider is capable of providing the needed services and can accept the individual for services.

Placement in an ALF should not be made for individuals requiring case management services unless the assessor can ensure that the appropriate services are available to the applicant/resident.

## **10. CASE DOCUMENTATION**

Case managers shall maintain a record of case management services provided to the ALF resident. The log shall list the date of all contacts between the case manager and the direct service providers, the ALF staff, and the resident. The log should summarize the nature of those contacts and cover services obtained for the resident, how the resident is responding, what unmet needs remain, and the progress that is being made toward securing still needed services. The log should also identify any changes in the resident's social, environmental, and medical circumstances.

## CHAPTER VII: REIMBURSEMENT PROCEDURES

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## **1. CONTRACTING WITH DMAS FOR REIMBURSEMENT**

All assessors and case managers performing assessments or providing Medicaid-funded ALF case management services must have a contract with DMAS to receive reimbursement for services. DMAS will reimburse only for assessment and Medicaid-funded targeted case management of individuals who are public pay (i.e., AG recipients or applicants).

Payment for Medicaid-funded targeted ALF case management services cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

## **2. BECOMING A MEDICAID PROVIDER OF SERVICES**

Public human services agencies cannot perform assessment services without a DMAS provider agreement. In order to officially authorize DMAS services, the agency must have a provider agreement. This assessment process is covered under the current Preadmission Screening (PAS) agreements or interagency agreement for hospitals and local health departments already performing PAS.

In order to become a Medicaid provider for ALF assessment and/or case management services, the provider must request a participation agreement by writing:

First Health Services/VMAP-PEU  
Post Office Box 26803  
Richmond, VA 23261-6803

Telephone: 804-270-5105  
Toll-free: 1-888-829-5373  
Fax: 804-270-7027

DMAS provider enrollment information is also available at:  
<http://165.176.249.159/search.asp?Userid=2&type=8>.

## **3. ASSESSMENT PACKAGES**

Each assessment package sent to DMAS for reimbursement is reviewed for accuracy, completeness, and adherence to DMAS policies and procedures. An incomplete, illegible, or inaccurate package will not be processed for payment. Reimbursement will be made only for an assessment which includes all the required forms that have been correctly completed and submitted and only for individuals who are eligible for an AG. The assessment package must be submitted to DMAS within 30 days of the assessment date to assure prompt reimbursement. There will be no reimbursement for assessments received by DMAS 12 months or more after the date of the completion of the assessment.

#### **4. REIMBURSEMENT FOR INITIAL ASSESSMENTS AND CHANGES IN LEVEL OF CARE**

The reimbursement process for initial assessments and changes in level of care are the same. When a recommendation is made that an individual meets ALF level of care, the assessor will document this decision on the UAI and the Medicaid Funded Long-Term Care Services Authorization (DMAS-96) and prepare an assessment package. The package is sent to:

First Health Services  
P.O. Box 85083  
Richmond, Virginia 23285-5083

The package for initial assessments and changes in level of care must include copies of:

- The DMAS-96
- The UAI, either short or long form as appropriate.

See Chapter II for procedures on the distribution of forms.

Initial assessments and changes in level of care assessments will be reimbursed by DMAS for AG recipients and applicants in the following amounts:

- \$100 for an initial full assessment;
- \$25 for an initial short assessment;
- \$100 for a change in level of care full assessment; and
- \$25 for change in level of care short assessment.

Assessors are advised to keep a log of assessments in order to ensure proper payments to their agencies or jurisdictions. Questions about reimbursements should be made in writing to:

Program Administration Supervisor  
Facility- and Home-Based Services Unit  
Division of Long-Term Care  
Department of Medical Assistance Services  
600 East Broad Street  
Richmond, Virginia 23219

*DMAS Facility- and Home-Based Services Unit staff may be reached at 804-225-4223.*

Information on many provider services is available at: <http://165.176.249.159/pr-home.htm>.

## **5. REIMBURSEMENT FOR ANNUAL REASSESSMENTS**

The reimbursement process for annual reassessments and ongoing targeted ALF case management are the same. Reimbursement for annual reassessments and targeted case management will be made by DMAS directly to the local assessment/case management agency.

Annual reassessments will be reimbursed by DMAS for AG recipients in the following amounts:

- \$25 for a short annual reassessment only.
- \$75 for a full annual reassessment only.

The assessor will document his or her reassessment decision on the ALF Eligibility Communication Document and prepare the assessment package. The package is sent to:

First Health Services  
P.O. Box 85083  
Richmond, Virginia 23285-5083

The package for annual reassessments must include copies of:

- The UAI, either short or long form as appropriate.
- ALF Eligibility Communication Document.
- CMS-1500.

Please see Chapter II for procedures on the distribution of forms following an annual reassessment or the provision of ongoing targeted ALF case management.

## **6. REIMBURSEMENT FOR ONGOING TARGETED ALF CASE MANAGEMENT**

Ongoing targeted ALF case management services will be reimbursed by DMAS for AG recipients in the following amount:

\$75 per quarter for ongoing Medicaid-funded targeted case management for AG recipients. If ongoing case management is authorized, the annual reassessment is included in that reimbursement.

Public agencies may only receive reimbursement for Medicaid-funded targeted ALF case management services when the individual is shown to need such services and the agency has a provider agreement with DMAS (See Chapter VI).

Reimbursement for case management services is limited to no more than one payment per each calendar quarter. In order to bill for case management services during a

calendar quarter, the case manager must comply with the documentation requirements and have a documented on-site visit with the resident during that quarter.

When a recommendation is made that an individual meets ALF level of care and is in need of case management services, the assessor will document this decision on the UAI and the Medicaid Funded Long-Term Care Services Authorization (DMAS-96) and prepare an assessment package. The package is sent to:

First Health Services  
P.O. Box 85083  
Richmond, Virginia 23285-5083

In order to receive reimbursement for case management, the case management provider must have a signed DMAS provider agreement and provider number. The provider number must be used on the invoices submitted to DMAS for ongoing Medicaid-funded targeted ALF case management services. Payments for ongoing Medicaid-funded ALF targeted case management and twelve-month reassessments will be made directly to the assessor or case management agency based on the submission of an invoice to DMAS.

For ongoing targeted ALF case management services, the case manager **completes the CMS-1500 only** and sends it to DMAS. This completed billing invoice must be sent in order for the case manager to be reimbursed. See section 8 for billing instructions. The case manager **will not send** the individual's plan(s) of care or the log that documents case management activity to DMAS. DMAS will review the required documentation during onsite visits to the ALF and the case management agencies. Copies of the individual's plan(s) of care should be provided to the ALF and the resident.

The CMS-1500 is sent to:

Practitioner  
Department of Medical Assistance Services  
P.O. Box 27444  
Richmond, VA 23261-7444

Please see Chapter III for procedures on the distribution of forms following an annual reassessment or the provision of ongoing targeted ALF case management.

## **7. REIMBURSEMENT TO THE ALF**

The ALF submits the admission package to DMAS, Division of Long-Term Care, to receive approval to bill DMAS for the provision of assisted or intensive assisted living services\*. The package includes a copy of the Individualized Service Plan and the DMAS-96.

The ISP should include the complete Provider Name, DMAS provider number, resident name, resident's complete Medicaid number, and the admission date of the resident to the facility.

The resident receives the AG payment and pays the ALF for care provided, regardless of whether he or she is receiving residential, regular assisted, or intensive assisted living\* level of services. The ALF bills DMAS on the CMS-1500 for the appropriate per diem rate (\$3 per day, not to exceed \$90 per month for assisted living).

\*Only those residents who were assessed at the intensive assisted living level of care on or before March 17, 2000, are eligible for the IAL reimbursement add-on. DMAS will reimburse \$6 per day, not to exceed \$180 per month for intensive assisted living (See Chapter IX).

## **8. COMPLETING THE CMS-1500**

The CMS-1500 (12-90) is a universally accepted claim form that is required when billing DMAS for such services as the annual reassessment and ongoing targeted ALF case management. The form is available from local business forms printers (check the Yellow Pages under "Business Forms and Systems") and from the U.S. Government Printing Office, Washington, DC 20402, telephone number 1-202-512-1800.

The CMS-1500 will not be provided by DMAS or CMS. **DMAS will NOT accept copies of the CMS-1500; only original CMS-1500 forms are acceptable.**

The only acceptable claims forms are those printed in Flint OCR Red J6983 ink (or an exact match). Although copies can be downloaded, copies cannot be used for submission of claims, since a downloaded copy may not accurately replicate the scale and OCR color of the form. The majority of paper claims sent to Medicare contractors are scanned using Optical Character Recognition (OCR) technology. The technology allows data contents contained on the form to be read while allowing the actual form fields, headings and lines to remain invisible. Photocopies and downloaded form may not permit accurate scanning.

In order to purchase claim forms, you should contact the U.S. Government Printing office at 202-512-1800, local printing companies and office supply stores. Each of these sources sells the CMS-1500 claim form in various configurations.

**Note: The required fields and codes used on the CMS-1500 are subject to change. To avoid reimbursement problems, local staff should periodically check Chapter V, "Billing Instructions", of the PreAdmission Screening manual to ensure they have the most current information. Chapter V may be accessed via the DMAS website at: [http://websrvr.dmas.virginia.gov/manuals/NHPAS/chapterV\\_nhpas.pdf](http://websrvr.dmas.virginia.gov/manuals/NHPAS/chapterV_nhpas.pdf)**

The following fields (locator numbers) **MUST** be completed for reimbursement:

- 1** Enter an "X" in the Medicaid box.
- 1a** **INSURED'S ID NUMBER.** Enter the 12-digit Virginia Medicaid number for the individual being assessed.
- 2** **PATIENT'S NAME.** Enter the name of the individual being assessed as it appears on the Medicaid identification: Last name, first name, and middle initial.
- 10** Complete ONLY if the individual's condition is related to employment, an auto accident, or another type of accident. If yes, enter an "X" in the appropriate box. For ALF assessments, this will usually be left blank.
- 10d** Complete ONLY if an attachment is being sent with the claim form.
- 21** **DIAGNOSIS:** For ALF assessments, LEAVE THIS FIELD BLANK.
- 22** **MEDICAID RESUBMISSION:** Complete ONLY if a claim adjustment or void is being submitted.
- 24A** **DATES OF SERVICE:** Enter the "from" and "through" dates in a 2-digit format for the month, day, and year (e.g., 03/15/07). For ALF assessments, the from and through dates will be the same (i.e., the date of the assessment if both the from and through date). Do not cross over months; for services that extend for a longer period of time than a one-day assessment, the dates must be within the same calendar month.
- 24B** **PLACE OF SERVICE:** For ALF assessments, always enter the 2-digit code "12" for resident's home.
- 24C** **TYPE OF SERVICE:** For ALF assessments, always enter the one-digit code "1" for medical care.
- 24D** **PROCEDURES, SERVICES, OR SUPPLIES:** Enter one of the following 5-digit CPT/HCPCS codes as appropriate to the claim:

<u>Old Code</u>	<u>New Code</u>	<u>Modifier</u>	<u>Description</u>	<u>Rate</u>
Z8574	T2022		ALF Targeted Case Management	\$75.00
Z8577	S0220		Annual Reassessment, short form	\$25.00
Z8578	S0220	U1	Annual Reassessment, long form (full UAI)	\$75.00

**24E     DIAGNOSIS CODE: NOT REQUIRED.**

**24F     CHARGES:** Enter the charge requested for the reassessment or case management service (i.e., \$25 for a short UAI annual reassessment (code *S0220*) and \$75 for the full UAI annual reassessment (code *S0220 U1*)). DMAS reimbursement for the annual reassessment, when it is performed during ongoing case management services, is \$75 (code *T2022*).

**24G     DAYS OR UNITS:** Enter the number of times the procedure, service, or item was provided during the service period. For ALF reassessments, enter “1” since the reassessment service is provided one time for the purpose of the claim. For case management, 1 unit = 1 quarter.

**24I     EMG (emergency):** Enter a “1” if the service is an emergency. Leave blank if it is not an emergency.

**24J     COB (coordination of benefits):** For ALF assessments, enter 2 – No other Carrier

**24K     RESERVED FOR LOCAL USE: LEAVE BLANK.**

**26     PATIENT’S ACCOUNT NUMBER:** This item is OPTIONAL. Enter the resident’s account number if desired. Up to seventeen alpha-numeric characters are accepted.

**31     SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES AND CREDENTIALS:** Enter the signature of the assessor with degrees and credentials and the date the assessment was completed. An individual designated by the assessment agency may sign the CMS-1500 as well.

**33     PHYSICIAN’S, SUPPLIER’S BILLING NAME, ADDRESS, ZIP CODE, AND PHONE:** Enter the assessment agency’s billing name, address, zip code, and telephone number as they appear in the Virginia Medicaid provider record. Enter the Virginia Medicaid provider number in the PINN # field. Do not enter anything in the GRP # field.

**ALL OTHER FIELDS ARE LEFT BLANK.**

## **9.     ADJUSTMENT OF THE CMS-1500**

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the CMS-1500 (12-90), except for the locator indicated below:

## **LOCATOR 22            Medicaid Resubmission**

Code: Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.

- 1023 Primary carrier has made additional payment.
- 1024 Primary carrier has denied payment.
- 1025 Accommodation charge correction.
- 1026 Patient payment amount changed.
- 1027 Correcting service periods.
- 1028 Correcting procedure/service code.
- 1029 Correcting diagnosis code.
- 1030 Correcting charges.
- 1031 Correcting units/visits/studies/procedures.
- 1032 IC reconsideration of allowance, documented.
- 1033 Correcting admitting, referring, prescribing, provider identification number.
- 1053 Adjustment reason is in Misc. category

### **10.        VOID OF THE CMS-1500**

**The Void Invoice is used to void a paid claim.** Follow the instructions for the completion of the CMS-1500 (12-90), except for the locator indicated below:

## **LOCATOR 22            Medicaid Resubmission**

Code: Enter the 4-digit code identifying the reason for the submission of the void invoice.

- 1042 Original claim has multiple incorrect items.
- 1044 Wrong provider identification number.
- 1045 Wrong recipient eligibility number.
- 1046 Primary carrier has paid DMAS maximum allowance.
- 1047 Duplicate payment was made.
- 1048 Primary carrier has paid full charge.
- 1051 Recipient not my patient.
- 1052 Void is for miscellaneous reasons.
- 1060 Other insurance available.

Adjustments and voids require the Original Reference Number/ICN in Locator 22. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted or voided. Only one claim can be adjusted or voided on each CMS-1500.

## CHAPTER VIII: ALZHEIMER'S ASSISTED LIVING (AAL) WAIVER

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## 1. INTRODUCTION

The 2004 General Assembly mandated that the Department of Medical Assistance Services (DMAS) develop a home- and community-based care waiver for individuals with Alzheimer's disease or a related dementia. This waiver became a reality in 2005 and will initially serve 200 individuals. Participants must reside in an assisted living facility (ALF) licensed by the Virginia Department of Social Services, be in a safe and secure environment, meet Virginia's criteria for nursing facility placement, and be receiving an Auxiliary Grant (AG). In order to participate in the waiver program, the ALF must operate a safe and secure special care unit and meet additional DMAS requirements as an approved provider. The individual must not have a diagnosis of mental retardation or serious mental illness.

The Alzheimer's Assisted Living Waiver (AAL) will allow individuals to:

1. Remain in a home-like setting for as long as possible or until substantially impaired;
2. Remain in an environment that maximizes their autonomy, privacy and dignity, even if they require a high level of services;
3. Enter a residential setting only when they develop substantial service needs; and
4. Avoid or delay placement in a nursing facility.

## 2. RECIPIENT ELIGIBILITY

Besides meeting all criteria for placement in an ALF, an individual applying for the AAL waiver must meet the following eligibility criteria:

1. An individual must have Alzheimer's or an Alzheimer's-related dementia diagnosed by a licensed clinical psychologist or a licensed physician. The individual **must not** have a diagnosis of mental retardation or a serious mental illness;
2. Does not have a prohibited condition as described by licensing standards (see Chapter II);
3. Be receiving or applying for an AG;
4. Be 55 years old or older; and
5. Meet nursing facility placement criteria as documented on the Virginia Uniform Assessment Instrument (UAI) by a PreAdmission Screening team.

## 3. RECIPIENT APPLICATION

Individuals, family members or legal representative who feel a person meets the criteria for the AAL waiver may submit a one-page application for the waiver. The application form, "Recipient Request for the Alzheimer's Assisted Living Waiver," is available at:

<http://165.176.249.159/SEARCH.ASP>. The form number is 478 and that number should be entered in “number/name “box on the web site. The form is also available by mail or telephone from DMAS at:

Department of Medical Assistance Services  
600 East Broad Street  
Richmond, VA 23219

Voice: 800-225-4222 (option one)  
TDD: 800-343-0634  
Fax: 804-786-0206

The application form is also available at the local departments of social services and local health departments. See Exhibit 1 for a copy of the application.

#### **4. RECIPIENT ENROLLMENT**

The completed application may be mailed or faxed to DMAS at:

Department of Medical Assistance Services  
Facilities and Home-Based Services Unit  
Alzheimer’s Assisted Living Waiver  
Recipient Applications  
600 East Broad Street  
Richmond, Virginia 23219

Fax: 804-786-0206

Before the applicant can be considered for the AAL Waiver, the following documents must be submitted to DMAS:

1. A completed UAI that demonstrates the need for nursing facility placement;
2. A completed Medicaid-Funded Long-Term Care Services Authorization Form (DMAS-96) that authorizes the AAL Waiver;
3. Proof that the applicant is receiving an AG;
4. A written diagnosis from a physician or licensed psychologist certifying that the applicant has Alzheimer’s or Alzheimer’s Related Dementia;
5. Proof that the applicant is 55 years of age or older; and
6. Documentation that the applicant is living or seeking admission to a Medicaid approved Alzheimer’s Assisted Living Waiver facility.

In order to speed consideration of the application, it is recommended that the required documents accompany the application.

All eligible applicants will be placed on a “candidate” list on a first-come, first-served basis. After the initial 200 eligible placements have been made, candidates will be notified as their names come up.

## **5. PLACEMENT**

Upon notification of the availability of an AAL waiver slot, the individual, family member or legal representative must make a placement in a DMAS-designated AAL provider within 30 days. If the placement cannot be completed within 30 days, DMAS can withdraw the waiver slot approval. DMAS realizes that there are circumstances when a person may not be able to complete a placement within 30 days and will evaluate each case on its own merit.

The AAL waiver provider must meet the licensing standards to operate a “Safe and Secure” special care unit and DMAS requirements as a designated provider. See Exhibit 2 for the current providers. Prospective AAL Waiver providers are encouraged to contact the Facilities and Home-Based Services Unit in the Division of Long-Term Care for more information.

## **6. CASE MANAGEMENT**

As a resident of an ALF, the recipient of the AAL Waiver is required to meet all of the assessment requirements for any ALF residents including an annual reassessment.

## **7. DISCHARGE FROM THE AAL WAIVER**

Recipients may be discharged from the AAL Waiver for the following reasons:

1. The recipient's condition worsens and a higher level of care is needed;
2. The recipient is no longer eligible for Medicaid;
3. The recipient is no longer eligible for AG;
4. The recipient has been absent from the ALF for more than 30 consecutive days;
5. The recipient no longer meets other waiver criteria;
6. The ALF no longer meets the “Safe and Secure” licensing standards;
7. The ALF no longer meets the requirements as a designated provider.

Decisions by DMAS to discharge a recipient from the AAL waiver may be appealed by the individual receiving AAL waiver services, a family member or his legal representative. See Chapter II for appeals information.

## Exhibit 1: Recipient Request for the Alzheimer's Assisted Living Waiver

### Virginia Department of Medical Assistance Services RECIPIENT REQUEST FOR THE ALZHEIMER'S ASSISTED LIVING WAIVER

This is a request to be screened for the Alzheimer's Assisted Living Waiver. Submission of this request form does not guarantee admission into the waiver or Medicaid eligibility. Complete the request form, print, sign, include all required attachments, and fax or mail to the address below.

Name: \_\_\_\_\_  
First Last

Medicaid Number \_\_\_\_\_

**The following material MUST be sent for your application to be considered complete:**

1. A completed Virginia Uniform Assessment Instrument (UAI), which demonstrates that you meet Medicaid Nursing Facility criteria. Check with your facility for a copy.
2. A completed Medicaid-Funded Long Term Care Service Authorization (DMAS – 96), which authorizes the Alzheimer's Assisted Living Waiver. Check with your facility for a copy.
3. Proof that you are receiving an Auxiliary Grant.
4. A written diagnosis of Alzheimer's or Alzheimer's related Dementia, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). You may get this from a physician or a licensed psychologist.
5. Proof that you are 55 years of age or older.
6. Documentation that you are living in or seeking admission to a Medicaid approved Alzheimer's Assisted Living Waiver facility.

#### **Application Certification:**

**I hereby certify that the above application and any attachments are a true and accurate representation of \_\_\_\_\_ current condition and status.**

Recipient name

Signature

Date

Signature of responsible party if unable to sign

Date

***\*\*Please return this completed form to:***

**DMAS**

Assisted Living Facility Asse  
Virginia Department of Socia

Division of Long Term Care & Quality Assurance  
600 East Broad Street  
Richmond, VA 23219  
or  
Fax to: (804) 786-0206



**Commonwealth of Virginia Department of Medical Assistance Services**  
**Division of Long Term Care ♦ 600 E. Broad Street, Richmond VA 23219 ♦ (804) 225-4222**

DMAS-478

## **Exhibit 2: DESIGNATED PROVIDERS**

### **Carriage Hill Retirement Community**

1203 Roundtree Drive  
Bedford, VA 24523  
Telephone: 540-586-5982  
Fax: 540-586-7334

### **Runk and Pratt of Forest, Inc**

208 Gristmill Drive  
Forest, VA 24551  
Telephone: 434-385-0297  
Fax: 434-237-0350

### **Kroontje Health Care Center**

1000 Litton Lane  
Blacksburg, VA 24060  
Telephone: 540-953-3200  
Fax: 540-961-0411

## CHAPTER IX: INTENSIVE ASSISTED LIVING LEVEL OF CARE

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## 1. BACKGROUND

Prior to March 17, 2000, there was a residential level of care and two levels of assisted living care in ALFs (regular assisted living and intensive assisted living) which were available to individuals who require assistance in activities of daily living and instrumental activities of daily living, which are above the room, board, and supervision provided by the ALF and reimbursed by the AG program.

The Intensive Assisted Living (IAL) waiver in ALFs became effective August 1, 1996. This waiver provided Medicaid payment to assisted living providers who provide a variety of services to residents that meet the IAL criteria, including personal care and services, homemaker, chore, attendant care, companion services, medication oversight, therapeutic social and recreational programming provided in a home-like environment in a licensed ALF, in conjunction with residing in the facility. These services also included 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence and provides supervision, safety, and security. Other individuals or agencies could also furnish care directly or under arrangement with the ALF, but the care provided by these other entities supplements that provided by the ALF and does not supplant it.

If licensed for assisted living, ALFs could opt to participate in DMAS' waiver program for IAL for AG recipients who met those criteria. To be reimbursed for IAL waiver services, ALFs needed to have a contract with DMAS to provide this level of care and must comply with DMAS' requirements for this waiver service. ALFs had to be licensed to provide assisted living before they could contract with DMAS to provide IAL services.

**In March 2000, the Health Care Financing Administration did not renew Virginia's Intensive Assisted Living Waiver. The IAL Waiver is no longer available as a Medicaid-funded alternative to nursing facility placement, on and after March 17, 2000, for new applicants. There are now only two levels of care in ALFs: residential care and assisted living.**

Individuals who previously would have been assessed at the IAL level of care may still reside in an ALF if all three of the following conditions are met:

- The individual does not have a prohibited condition;
- The ALF is licensed at the assisted living level; and
- The ALF is willing and able to meet all of the individual's care needs, including personal care and any mental health and/or mental retardation needs that may exist.

State funds are being used to supplement the federal share of the IAL payment for residents assessed at the IAL level of care on or before March 17, 2000. **No new**

**individuals may be assessed at the IAL level of care and there can be no IAL payment for individuals assessed at this level after March 17, 2000.**

Documentation on the Virginia UAI should continue to clearly and accurately describe the care needs of the individual. DMAS is continuing to conduct reviews of IAL recipients, and, as long as the ALF accepts the additional \$180 per month for “grandfathered” IAL residents, will expect to see the care provided in the IAL Waiver before the waiver’s non-renewal. Only those residents who were assessed at the IAL level of care on or before March 17, 2000, are eligible for the IAL reimbursement add-on. DMAS will reimburse \$6 per day, not to exceed \$180 per month for IAL services.

DMAS will pay the ALF for services rendered while the individual is determined to be eligible for benefits under the AG program and authorized for assisted living care. The assisted living authorization is considered effective as of the date the Medicaid-Funded Long-Term Care Services Authorization (DMAS-96) is signed and dated, except in the case of an emergency placement as defined in Chapter V, the assisted living authorization is considered effective as of the date of the emergency placement, provided that the Medicaid Funded Long-Term Care Services Authorization (DMAS-96) is signed and dated within seven working days after the date of the emergency placement.

In addition, in order for assisted living payments to be made to a facility, the assisted living authorization must be based on a UAI that complies with the requirements of *Code of Virginia*, § 63.2-1804. DMAS will continue to provide a per diem fee of \$3 for each individual authorized to receive assisted living services.

## **2. CRITERIA FOR INTENSIVE ASSISTED LIVING IN AN ALF**

Individuals meet the criteria for intensive assisted living as documented on the UAI when at least one of the following describes their capacity:

1. Rated dependent in four or more of seven ADLs (page 4 of UAI).
2. Rated dependent in two or more ADLs and rated as semi-dependent or dependent in a combination of behavior pattern (i.e., abusive, aggressive, or disruptive) and orientation (page 8 of UAI).
3. Rated semi-dependent in two or more ADLs and dependent in the combination behavior and orientation.

## **3. DIFFERENCE BETWEEN IAL AND NURSING FACILITY CRITERIA**

The differences between nursing facility criteria and intensive assisted living criteria are:

1. Identification of nursing needs is not required for an ALF resident with 4 ADLs; and
2. Medication administration, joint motion, and mobility are not factors considered in authorizations for IAL level of care.

#### **4. MEDICAID NURSING FACILITY AND COMMUNITY-BASED SERVICES CRITERIA**

The preadmission screening process preauthorizes a continuum of long-term care services available to an individual under the Virginia Medical Assistance Program. Medicaid-funded long-term care services may be provided in either a nursing facility or community-based care setting.

##### **4.1 Nursing Facility Criteria**

The criteria for assessing an individual's eligibility for Medicaid payment of nursing facility care consists of two components:

1. Functional capacity (the degree of assistance an individual requires to complete activities of daily living); and
2. Medical or nursing needs.

To qualify for Medicaid payment for nursing facility care, an individual must meet both functional capacity requirements and have a medical condition that requires ongoing medical or nursing management. An exception may be made when the individual does not meet the functional capacity requirement but the individual does have a health condition that requires the daily direct services of a licensed nurse that cannot be managed on an outpatient basis.

##### **4.2 Community-Based Criteria**

The criteria for assessing an individual's eligibility for Medicaid payment of community-based care consist of three components:

1. Functional capacity (the degree of assistance an individual requires to complete activities of daily living);
2. Medical or nursing needs; and
3. The individual's risk of nursing facility placement in the absence of community-based waiver services.

To qualify for Medicaid payment for community-based care, an individual must either meet both the functional and medical components of the nursing facility criteria and be at risk of nursing facility placement without the provision of community-based services.

## **5. ANNUAL REASSESSMENTS AND CHANGE IN LEVEL OF CARE ASSESSMENTS**

If during an annual reassessment or a change in level of care assessment (see Chapter III), the resident appears to meet the criteria for nursing facility level of care, the assessor or case manager should refer the resident to the local PreAdmission Screening (PAS) team. See Chapter II for handling the referral and Chapter VII submitting the assessment for reimbursement.

## **6. COMPLETING THE ALF ELIGIBILITY COMMUNICATION DOCUMENT FOR IAL**

Under the PURPOSE OF COMMUNICATION SECTION, check either 1, 2, or 3.

If 1 is checked (Annual Reassessment Completed), fill in the date of the reassessment. Check either a. Resident continues to meet criteria for ALF placement at the following level of care or b. Resident does not meet criteria for residential or assisted living. If a. is checked, indicate which level of care the individual meets. If the resident being assessed is one of the “grandfathered” IAL placements who has been assessed at the IAL level of care, indicate in the space available that the resident “continues to need intensive assisted living services” and “based on the UAI, continues to meet criteria for intensive assisted living.” When 1 is checked, the assessor sends a copy of the Uniform Assessment Instrument (UAI), the ALF Eligibility Communication Document (ECD), and the CMS-1500 to DMAS. In addition, the assessor sends a copy of the ECD to the LDSS eligibility worker; copies of the UAI and ECD to the ALF; and a decision letter to the individual being assessed. The assessor should keep a copy of each of these documents.

# APPENDIX A

## CONTACT INFORMATION

# CONTACTS

## DEPARTMENT OF SOCIAL SERVICES

7 North Eight Street, Richmond, VA 23219

<http://www.dss.virginia.gov/family/as/>

### Adult Services Program

Gail Nardi, Manager, Adult Services Programs	804-726-7533
Tishaun Harris-Ugworji, Adult Services Programs Consultant	804-726-7537
Paige McCleary, Adult Services Programs Consultant	804-726-7560
Venus Bryant, Administrative Assistant	804-726-7536
FAX	804-726-7533

### VDSS Regional Adult Services Consultants

Central Region	Barbara Jenkins	804-662-9783
Eastern Region	temporarily vacant	contact another consultant
Northern Region	David Stasko	540-347-6313
Piedmont Region	Bill Parcell	540-483-6856
Western Region	Carol McCray	276-676-5636

### VDSS Division of Licensing Programs 804-726-7163

<http://www.dss.virginia.gov/division/license/district.html>

#### *VDSS Division of Licensing Programs Field Offices*

Abingdon	276-676-9743
Fairfax	703-943-1505
Henrico	804-662-9743
Peninsula	757-594-7594
Piedmont	540-857-7920
Verona	540-332-2330
Virginia Beach	757-347-3990
Warrenton	540-347-6345

### VDSS Division of Temporary Assistance (Benefits) 804-726-7357

<http://www.dss.virginia.gov/benefit/>

## DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Division of Long-Term Care, 600 East Broad Street, Richmond, VA 23219

Terry A. Smith, Director, Division of Long-Term Care	804-371-8490
Bill Butler, Manager, Facility and Home-Based Services	804-371-8886
Melissa Fritzman, Supervisor, Facility and Home-Based Services	804-225-4206
Marjorie Marker, Long-Term Care Policy Analyst	804-225-2536

Bertha Ventura, Office Services Supervisor  
Fax: 804-371-4986  
<http://www.dmas.virginia.gov>.

804-692-0481

**DEPARTMENT FOR THE AGING**

1610 Forest Avenue, Suite 100, Richmond, VA 23229  
Information 804-662-9333 or 1-800-552-3402  
<http://www.vda.virginia.gov>

**DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES**

109 Governor Street, Richmond, VA 23219  
Information 804-371-0769  
<http://www.dmhmrzas.virginia.gov>

**DEPARTMENT OF HEALTH**

109 Governor Street, P.O. Box 2448, Richmond, Virginia 23218-2448  
Information 804-367-2100  
<http://www.vdh.state.va.us/>

**DEPARTMENT OF REHABILITATIVE SERVICES**

8004 Franklin Farms Drive, Richmond, VA 23229  
Information 1-800-552-5019, 1-800-464-9950 (TTY)  
<http://www.vadrs.org/>

**DEPARTMENT OF CORRECTIONS**

6900 Atmore Drive, P.O. Box 26963, Richmond, VA 23225  
804-674-3000  
<http://www.vadoc.state.va.us/>

**COMMONWEALTH OF VIRGINIA STATE WEB SITE LIST**

[http://www.virginia.gov/cmsportal2/government\\_4096/state\\_website\\_list.html](http://www.virginia.gov/cmsportal2/government_4096/state_website_list.html)

# APPENDIX B

## ASSISTED LIVING FACILITY CRITERIA

# **ASSISTED LIVING FACILITY CRITERIA**

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## **AUTHORIZATION OF SERVICES TO BE PROVIDED**

The assessor is responsible for authorizing the appropriate level of care for admission to and continued stay in an assisted living facility (ALF). The ALF must also be knowledgeable of level of care criteria and is responsible for discharge of the resident whenever a resident does not meet the criteria for level of care in an ALF upon admission or at any later time. The appropriate level of care must be documented based on the completion of the Uniform Assessment Instrument (UAI) and definitions of activities of daily living and directions provided in the *User's Manual: Virginia Uniform Assessment Instrument*.

## **CRITERIA FOR RESIDENTIAL LIVING IN AN ALF**

Individuals meet the criteria for residential living as documented on the UAI when at least one of the following describes their functional capacity:

1. Rated dependent in only one of seven ADLs (i.e., bathing, dressing, toileting, transferring, bowel function, bladder function, and eating/feeding); OR
2. Rated dependent in one or more of four selected IADLs (i.e., meal preparation, housekeeping, laundry, and money management): OR
3. Rated dependent in medication administration.

## **CRITERIA FOR ASSISTED LIVING IN AN ALF**

Individuals meet the criteria for regular assisted living as documented on the UAI when at least one of the following describes their capacity:

1. Rated dependent in two or more of seven ADLs; OR
2. Rated dependent in behavior pattern (i.e., abusive, aggressive, and disruptive).

## **RATING OF LEVELS OF CARE ON THE UNIFORM ASSESSMENT INSTRUMENT**

The rating of functional dependencies on the preadmission screening assessment instrument must be based on the individual's ability to function in a community environment, not including any institutionally induced dependence. Please see the *User's Manual: Virginia Uniform Assessment Instrument* for more detailed definitions.

The following abbreviations shall mean: I = independent; d = semi-dependent; D = dependent; MH = mechanical help; HH = human help.

**(1) Bathing**

- (a) Without help **(I)**
- (b) MH only **(d)**
- (c) HH only **(D)**
- (d) MH and HH **(D)**
- (e) Is bathed **(D)**

**(2) Dressing**

- (a) Without help **(I)**
- (b) MH only **(d)**
- (c) HH only **(D)**
- (d) MH and HH **(D)**
- (e) Is dressed **(D)**
- (f) Is not dressed **(D)**

**(3) Toileting**

- (a) Without help day or night **(I)**
- (b) MH only **(d)**
- (c) HH only **(D)**
- (d) MH and HH **(D)**
- (e) Does not use toilet room **(D)**

**(4) Transferring**

- (a) Without help **(I)**
- (b) MH only **(d)**
- (c) HH only **(D)**
- (d) MH and HH **(D)**
- (e) Is transferred **(D)**
- (f) Is not transferred **(D)**

**(5) Bowel Function**

- (a) Continent **(I)**
- (b) Incontinent less than weekly **(d)**
- (c) Ostomy self-care **(d)**
- (d) Incontinent weekly or more **(D)**
- (e) Ostomy not self-care **(D)**

**(6) Bladder Function**

- (a) Continent **(I)**
- (b) Incontinent less than weekly **(d)**
- (c) External device self-care **(d)**
- (d) Indwelling catheter self-care **(d)**
- (e) Ostomy self-care **(d)**
- (f) Incontinent weekly or more **(D)**
- (g) External device, not self-care **(D)**
- (h) Indwelling catheter, not self-care **(D)**
- (i) Ostomy not self-care **(D)**

**(7) Eating/Feeding**

- (a) Without help **(I)**
- (b) MH only **(d)**
- (c) HH only **(D)**
- (d) MH and HH **(D)**
- (e) Spoon fed **(D)**
- (f) Syringe or tube fed **(D)**
- (g) Fed by IV or clysis **(D)**

**(9) Joint Motion (NF)**

- (a) Within normal limits **(I)**
- (b) Limited motion **(d)**
- (c) Instability corrected **(I)**
- (d) Instability uncorrected **(D)**
- (e) Immobility **(D)**

**(10) Mobility**

- (a) Goes outside without help **(I)**
- (b) Goes outside MH only **(d)**
- (c) Goes outside HH only **(D)**
- (d) Goes outside MH and HH **(D)**
- (e) Confined moves about **(D)**
- (f) Confined does not move about **(D)**

**(8) Behavior Pattern and Orientation**

- (a) Appropriate or than Wandering/Passive less weekly + Oriented **(I)**
- (b) Appropriate or Wandering/Passive < weekly + Disoriented Some Spheres **(I)**
- (c) Wandering/Passive Weekly/or more + Oriented **(I)**
- (d) Appropriate or Wandering/Passive < weekly + Disoriented All Spheres **(d)**
- (e) Wandering/Passive Weekly or more + Disoriented Some or All Spheres **(d)**
- (f) Abusive/Aggressive/Disruptive < weekly + Oriented or Disoriented **(d)**
- (g) Abusive/Aggressive/Disruptive weekly or more + Oriented **(d)**
- (h) Abusive/Aggressive/Disruptive weekly or more + Disoriented **(D)**

- |                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>(11) Medication Administration (NF)</b></p> <ul style="list-style-type: none"> <li>(a) No medications <b>(I)</b></li> <li>(b) Self-administered, monitored &lt; weekly <b>(I)</b></li> <li>(c) By lay persons, monitored &lt; weekly <b>(I)</b></li> <li>(d) By Licensed/Professional nurse and/or monitored weekly or more <b>(d)</b></li> <li>(e) Some or all by Professional nurse <b>(D)</b></li> </ul> | <p><b>(12) Medication Administration (ALF)</b></p> <ul style="list-style-type: none"> <li>(a) Without assistance <b>(I)</b></li> <li>(b) Administered, monitored by lay person <b>(D)</b></li> <li>(c) Administered, monitored by professional staff <b>(D)</b></li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <p><b>(13) Behavior Pattern</b></p> <ul style="list-style-type: none"> <li>(a) Appropriate <b>(I)</b></li> <li>(b) Wandering/passive less than weekly <b>(I)</b></li> <li>(c) Wandering/passive weekly or more <b>(d)</b></li> <li>(d) Abusive/aggressive/disruptive less than weekly</li> <li>(e) Abusive/aggressive/disruptive weekly or more <b>(D)</b></li> </ul>                                             | <p><b>(14) Instrumental Activities of Daily Living (ALF)</b></p> <ul style="list-style-type: none"> <li>(a) Meal Preparation               <ul style="list-style-type: none"> <li>(1) No help needed</li> <li>(2) Needs help <b>(D)</b></li> </ul> </li> <li>(b) Housekeeping               <ul style="list-style-type: none"> <li>(1) No help needed</li> <li>(2) Needs help <b>(D)</b></li> </ul> </li> <li>(c) Laundry               <ul style="list-style-type: none"> <li>(1) No help needed</li> <li>(2) Needs help <b>(D)</b></li> </ul> </li> <li>(d) Money Management               <ul style="list-style-type: none"> <li>(1) No help needed</li> <li>(2) Needs help <b>(D)</b></li> </ul> </li> </ul> |

For more detailed descriptions of each of the above, please refer to the *User's Manual: Virginia Uniform Assessment Instrument* (July 2005).

## BATHING

Bathing is the process of washing the body or body parts, including getting to or obtaining the bathing water and/or equipment whether this is in the bed, shower, or tub.

- Bathes without Help means the individual usually completes the entire bathing process unaided, or receives help to bathe one body part only.
- Bathes with Mechanical Help Only means the individual usually uses equipment or a device to complete the bathing process. Equipment or device includes shower/tub chair, grab rails, pedal/knee controlled faucet, long-handled brush, and mechanical lift.

- Bathes with Human Help Only means the individual usually receives assistance from another person(s) who may bring water/equipment, bathe some body parts, fill the tub with water, towel dry, observe, supervise, or teach the individual to bathe self.
- Bathes with Mechanical and Human Help means the individual usually uses equipment or a device and receives the assistance of another person.
- Is Bathed means the individual is completely bathed by another person(s) and does not participate in the activity.
- Does Not Bathe means the individual does not perform the bathing process, and it is not performed by another person.

The type of mechanical help and/or the number of human assistants used are specified in the spaces provided.

## **DRESSING**

Dressing is the process of putting on, fastening, and taking off all items of clothing, braces and artificial limbs that are worn daily by the individual including obtaining and replacing the items from their storage area in the immediate environment. Clothing refers to the clothing usually worn daily by the individual. Individuals who wear pajamas or a gown with robe and slippers as their usual attire are considered dressed.

- Dresses without Help means the individual usually completes the dressing process unaided, or receives help in tying shoes only.
- Dresses with Mechanical Help Only means the individual usually uses equipment or a device to complete the dressing process. Equipment or device may include long-handled shoehorn, zipper pulls, velcro fasteners, adapted clothing, and walker with attached basket or other device to obtain clothing.
- Dresses with Human Help Only means the individual usually receives assistance from another person(s) who helps the individual in obtaining clothing; fastening hooks; putting on clothes, braces, artificial limbs; observes, supervises, or teaches the individual to dress self.
- Dresses with Mechanical and Human Help means the individual usually uses equipment or a device and receives the assistance of another person(s) to dress.
- Is Dressed means the individual is completely dressed by another person.
- Is Not Dressed refers only to bedfast individuals who are considered not dressed.

The type of mechanical help and/or number of human assistants used are specified in the spaces provided.

## **TOILETING**

Toileting is the process of getting to and from the toilet room for elimination of feces and urine, transferring on and off the toilet, cleaning self after elimination, and adjusting clothes. A commode in any location may be considered the "toilet room" only if in addition to meeting the criteria for "toileting," the individual empties, cleanses, and replaces the receptacle without assistance from another person(s).

- Uses Toilet Room without Help Day and Night means the individual usually uses only the toilet room for elimination.
- Uses Toilet Room with Mechanical Help Only means the individual usually uses equipment or a device to get into or out of the toilet room, or other device to complete the toileting process. Equipment or device may include raised toilet or seat, handrails, wheelchair, walker, cane or transfer board. The individual who toilets without help during the day but uses a bedpan, urinal, or commode without human help to toilet during the night is considered to be toileting without help.
- Uses Toilet Room with Human Help Only means the individual usually receives assistance from another person(s) to complete the toileting process. Help from another person(s) means another person(s) helps the individual in getting to and from the toilet room, adjusting clothes, transferring on and off the toilet, or cleaning after elimination.
- Uses Toilet Room with Mechanical and Human Help means the individual usually uses equipment or a device and receives the assistance of another person(s).
- Does Not Use Toilet Room means the individual usually uses a bedpan, urinal, or commode for elimination or is incontinent and does not use the toilet room.

The type of mechanical help and/or number of human assistants used are specified in the space provided.

## **TRANSFERRING**

Transferring is the process of moving horizontally and/or vertically between the bed, chair, wheelchair, and/or stretcher.

- Transfers without Help means the individual usually completes the transferring process unaided.

- Transfers with Mechanical Help Only means the individual usually uses equipment or a device to transfer. Equipment or device includes: sliding board, overhead pulley, trapeze, special bed, railing on bed, tub, toilet, walker, or the arm of a chair, etc.
- Transfers with Human Help Only means the individual usually receives the assistance of another person(s) lifting some of the individual's body weight, guarding, guiding, protecting, or supervising in the process of transferring.
- Transfers with Mechanical and Human Help means the individual usually uses mechanical equipment or a device and receives assistance from another person(s). The individual who bears weight on at least one arm or is considered to be participating in transferring.
- Is Transferred means the individual usually is lifted out of bed, chair, etc., by another person(s) and does not participate in the process. If the individual does not bear weight on any body part in the transferring process she or he is not participating in transferring. This category may also include the use of equipment or devices such as a mechanical lift, Hoyer lift, etc.
- Is Not Transferred means the individual is confined to bed.

The type of mechanical help and/or number of human assistants used are specified in space provided.

## **BOWEL FUNCTION**

Bowel Function is the physiological process of elimination of feces from the bowel.

- Continent means the individual voluntarily controls the evacuation of feces from his or her bowels.
- Incontinent means the individual has involuntary evacuation of feces from his or her bowels.
- Ostomy is a surgical procedure that establishes an artificial anus by an opening into the colon (colostomy) or ileum (ileostomy).
- Self-Care means that the individual completely cares for his or her ostomy.
- Not Self-Care means that another person(s) cares for the individual's ostomy: stoma and skin cleaning, dressing, application of appliance, irrigations, etc.

The type of ostomy or other bowel problem; e.g., constipation, is specified in the space provided.

## **BLADDER FUNCTION**

Bladder Function is the physiological process of elimination of urine from the bladder.

- Continent means the individual voluntarily empties his or her bladder.
- Incontinent means the individual has involuntary emptying or loss of urine.
- External Device is a urosheath or condom drainage apparatus with a receptacle attached to collect urine.
- Indwelling Catheter is a hollow cylinder passed through the urethra into the bladder and retained there to keep the bladder drained of urine.
- Ostomy is a surgical procedure that establishes an external opening into the ureter(s).

--Self-Care means the individual completely cares for the skin surrounding the ostomy and for urinary devices; e.g., changes the catheter or external device, irrigates as needed, and empties and replaces the receptacle.

--Not Self-Care means another person(s) cares for the individual's ostomy or urinary devices.

The type of ostomy or other urinary problem; e.g., retention, is specified in the space provided.

## **EATING/FEEDING**

Eating/Feeding is the process of getting food by any means from the receptacle (plate, cup, glass, bottle, etc.) into the body. This item describes the process of eating after food is placed in front of an individual.

- Feeds Self without Help means the individual usually eats unaided.
- Feeds Self with Mechanical Help Only means the individual usually uses equipment or a device to eat. Equipment or device includes adapted utensils, plate guard, hand splint, suction dishes or nonskid plates, etc.
- Feeds Self with Human Help Only means the individual usually receives the assistance of another person(s) to bring food to the mouth, cut meat, butter bread,

open cartons, or pour liquids. Mechanically adjusted diets such as ground, pureed, soft, etc., are not considered help.

- Feeds Self with Mechanical and Human Help means the individual usually uses equipment or a device and receives the help of another person(s).
- Is Spoon Fed means the individual usually does not bring any food to his or her mouth and is fed completely by another person(s).
- Fed via Syringe or Tube means the individual usually is fed a prescribed liquid diet via a naso-oral gavage or gastrogavage tube.
- Fed by I.V. or Clysis means the individual usually is fed a prescribed sterile solution intravenously or by clysis.

The type of mechanical and/or human help used, or additional information about syringe, tube, I.V., or clysis feedings is specified in the spaces provided.

## **BEHAVIOR PATTERN**

Behavior Pattern is the manner of conducting oneself within one's environment.

- Appropriate means the individual's behavior pattern is suitable or fitting to the environment. Appropriate behavior is of the type that adjusts to accommodate expectations in different environments and social circumstances. Behavior pattern does not refer to personality characteristics such as "selfish," "impatient," or "demanding," but is based on direct observations of the individual's actions.
- Inappropriate Wandering, Passive, or Other means the individual's usual behavior is manifested in a way that does not present major management problems. Wandering is characterized by physically moving about aimlessly or mentally being non-focused. Passive behavior is characterized by a lack of awareness or interest in personal matters and/or in activities taking place in close proximity. Other characterizations of behavior such as impaired judgment, regressive behavior, agitation or hallucinations that is not disruptive are included in this category and specified in the space provided.
- Inappropriate Abusive, Aggressive, or Disruptive means the individual's behavior is manifested by acts detrimental to the life, comfort, safety, and/or property of the individual and/or others. Agitations, hallucinations, or assaultive behavior that is detrimental are included in this category and specified in the space provided.
- Comatose refers to the semi-conscious state.

The type of inappropriate behavior is specified in the space provided. I refers to independence of the individual in behavior management.

## **ORIENTATION**

Orientation is the awareness of an individual within his or her environment in relation to time, place and person.

- Oriented means the individual is aware of who he or she is, where he or she is and what time, day, month or year it is.
- Disoriented-Some Spheres, Sometime means the individual is disoriented in one or two spheres, time only or time and place, some of the time. Some of the time refers to alternating periods of awareness-unawareness.
- Disoriented-All Spheres, All Time means the individual is disoriented in one or two spheres, time only or time and place, and this is the individual's usual state.
- Disoriented-All Spheres, Sometime means the individual is disoriented to time, place and person (all three spheres) some of the time.
- Disoriented-All Spheres, All Time means the individual is always unaware of time, place and his or her identity.
- Comatose refers to the semi-conscious or unconscious state.

The spheres to which the individual is disoriented are specified in the space provided. I refers to independent; the individual is oriented.

## **MEDICATION ADMINISTRATION**

Medication Administration refers to the person(s) who administer medications or if the individual is being referred elsewhere, the person(s) who will administer medications following referral.

- No Medications means the individual does not receive oral or injectable medications.
- Self-Administered, Monitored Less Often Than Weekly means the individual takes (or will take) medications without assistance and the effects of drug taking are (to be) observed by licensed or professional health personnel less often than weekly.
- Administered by a Lay Person, Monitored Less Often Than Weekly means a person without pharmacology training gives (or will give) the individual all of the prescribed

medications or gives some of them and the remaining medications are (to be) self-administered. Monitoring the effects of drug taking are (to be) observed by licensed or professional health personnel less often than weekly.

- Administered by Licensed or Professional Health Personnel and/or Monitored Weekly or More Often means licensed or professional health personnel administer (or will administer) some or all of the individual's medications. Other medications may be self-administered or given by a person(s) without pharmacology training. The effects of drug taking are (to be) monitored weekly or more often by licensed or professional health personnel.
- Administered by a Professional means a health professional with additional special training administers (or will administer) and/or monitors specific medications; e.g., IV.s, potent experimental drugs, etc. Other medications are (will be) administered by licensed or professional health personnel, lay person(s) or self-administered.

# APPENDIX C

# FORMS

## FORMS USED IN THE ASSISTED LIVING FACILITY (ALF) ASSESSMENT PROCESS

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### **FORMS**

#### **Virginia Uniform Assessment Instrument (UAI)**

Use to assess public pay (i.e., Auxiliary Grant) applicants to and residents of an ALF.

Available at: <http://www.dss.virginia.gov/family/as/forms.cgi>

#### **Virginia UAI Add-on Page** (Use of this form is optional.)

One paged assessment to be used with the short form of the UAI to answer questions on medication administration from page 5 of the full UAI and behavior pattern and orientation from page 8 of the UAI.

Available at: <http://www.dss.virginia.gov/family/as/forms.cgi>

#### **Virginia UAI-Private Pay**

Used to assess private pay individuals applicants and residents of an ALF.

Available at: <http://www.dss.virginia.gov/family/as/forms.cgi>

#### **Medicaid-Funded Medicaid Funded Long-Term Care Services Authorization (DMAS-96)**

Use at *initial assessment and when there is a change in level of care*. Must be sent to DMAS in order to receive reimbursement for assessment.

Available at: <http://165.176.249.159/SEARCH.ASP>

#### **CMS-1500**

Billing invoice used to request reimbursement from DMAS for annual reassessment and ongoing targeted ALF case management.

#### **Worksheet to Determine ALF Level of Care** (Use of this form is optional.)

Use to tally results of UAI assessment to quickly determine an individual's level of care.

Available at: <http://www.dss.virginia.gov/family/as/forms.cgi>

#### **Assisted Living Facility Eligibility Communication Form**

Use to notify local department of social services eligibility worker and DMAS of annual reassessment.

Available at: <http://www.dss.virginia.gov/family/as/forms.cgi>

#### **UAI Plan of Care**

Used by case manager to develop plan of care based on completed UAI for ALF residents receiving ongoing Medicaid-funded targeted case management.

Available at: <http://www.dss.virginia.gov/family/as/forms.cgi>

#### **Interagency Consent to Release Confidential Information about Alcohol and Drug Patients**

Available at: <http://www.dss.virginia.gov/family/as/forms.cgi>

**Consent to Release Information**

Available at: <http://www.dss.virginia.gov/family/as/forms.cgi>

**Request for Appeal**

Form used to request an appeal for denial of an Auxiliary Grant.

Available at: <http://www.dss.virginia.gov/family/as/forms.cgi>

**Recipient Request for the Alzheimer's Assisted Living Waiver**

Available at: <http://165.176.249.159/SEARCH.ASP>.

***With the exception of the CMS-1500, plain paper copies of these forms are acceptable.***

## **MANUALS USED IN THE ASSISTED LIVING FACILITY (ALF) ASSESSMENT PROCESS**

**UAI Manual: Virginia Uniform Assessment Instrument (July 2005)**

Available at: [http://www.dss.virginia.gov/family/as/uai\\_manual.cgi](http://www.dss.virginia.gov/family/as/uai_manual.cgi)

**UAI-Private Pay Manual**

Available at: [http://www.dss.virginia.gov/family/as/uai\\_manual.cgi](http://www.dss.virginia.gov/family/as/uai_manual.cgi)

**Assisted Living Facility Assessment Manual**

Available at: <http://www.dss.virginia.gov/family/as/aps.cgi>

**WHERE TO GET FORMS****Forms Available from the Department of Medical Assistance Services (DMAS)**

DMAS provides access to provider forms via:

- The DMAS web site <http://165.176.249.159/default.htm>
- Form copies in Medicaid provider manuals

DMAS Manuals are available at: [http://165.176.249.159/prm-provider\\_manuals.htm](http://165.176.249.159/prm-provider_manuals.htm)

**Forms Available from VDSS**

- The forms and manuals are available from the Virginia Department of Social Services, Adult Services Programs at: <http://www.dss.virginia.gov/family/servtoadult.html>.

### **Forms Available from Other Sources**

#### **CMS-1500**

The CMS-1500 (12-90) is a universally accepted claim form that is required when billing DMAS for such services as case management. The form is available from the U.S. Government Printing Office (telephone number 202-512-1800) and from business forms printers (consult your local *Yellow Pages* under “Business Forms” for vendors). The CMS-1500 (12-90) will not be provided by DMAS. Only original forms (no photocopies) will be accepted.

**WORKSHEET TO DETERMINE ALF LEVEL OF CARE**  
(The use of this worksheet is optional.)

**Resident's Name:** \_\_\_\_\_

**STEP 1: Based on the completed UAI, complete sections below.**

<b>ADLs</b>	<b>Check if Dependent (D)</b>
Bathing	
Dressing	
Toileting	
Transferring	
Eating/Feeding	
Bowel	
Bladder	

Number of ADL Dependencies: \_\_\_\_\_

<b>Selected IADLs</b>	<b>Check if Dependent (D)</b>
Meal Preparation	
Housekeeping	
Laundry	
Money Management	

Number of IADL Dependencies: \_\_\_\_\_

Medication Administration: Check here if Dependent \_\_\_\_\_

Behavior Pattern: Check here if Dependent \_\_\_\_\_

Behavior Pattern and Orientation: Check here if  
Semi-Dependent or Dependent \_\_\_\_\_

The resident has no prohibited conditions per the  
Code of Virginia, § 63.2-1805. \_\_\_\_\_

**STEP 2: Apply the above responses to the criteria below to determine where the individual fits and circle the appropriate level of care.**

**RESIDENTIAL LIVING LEVEL OF CARE IN AN ALF:**

1. Rated dependent in only one of seven ADLs; OR
2. Rated dependent in one or more of four selected IADLs; OR
3. Rated dependent in medication administration.

**REGULAR ASSISTED LIVING LEVEL OF CARE IN AN ALF:**

1. Rated dependent in two or more of seven ADLs; OR
2. Rated dependent in behavior pattern.

**VIRGINIA DEPARTMENTS OF MEDICAL ASSISTANCE SERVICES/  
SOCIAL SERVICES ASSISTED LIVING FACILITY  
ELIGIBILITY COMMUNICATION DOCUMENT**

---

**To/From:** Dept. of Social Services Eligibility Worker in \_\_\_-

\_\_\_\_\_  
(City/County Responsible for Auxiliary Grant)

Address: \_\_\_\_\_  
\_\_\_\_\_

**To/From:** \_\_\_\_\_

\_\_\_\_\_  
(ALF Assessor/Case Manager)

Address: \_\_\_\_\_  
\_\_\_\_\_

---

Assessor's provider #: \_\_\_\_\_

**RESIDENT:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**ALF and Location:** \_\_\_\_\_  
\_\_\_\_\_

Medicaid #: \_\_\_\_\_

---

**PURPOSE OF COMMUNICATION (check 1, 2, or 3):**

- \_\_\_ **1. ANNUAL REASSESSMENT COMPLETED ; Date of Reassessment:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
a. \_\_\_ **Resident Continues to Meet Criteria for ALF Placement at the following level of care:**  
\_\_\_\_ Residential Living \_\_\_\_ Assisted Living  
b. \_\_\_ **Resident Does Not Meet Criteria for Residential or Assisted Living**
- \_\_\_ **2. RESIDENT NO LONGER RESIDES IN ALF ON RECORD.** Resident has been discharged to:  
a. \_\_\_ **Another ALF.** Last Date of Service in the ALF on Record: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name of New ALF : \_\_\_\_\_  
\_\_\_\_\_  
Provider #: \_\_\_\_\_ Start of Care Date in New ALF: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address of New ALF: \_\_\_\_\_  
ALF: \_\_\_\_\_  
b. \_\_\_ **Home.** Last Date of Service in the ALF: \_\_\_\_/\_\_\_\_/\_\_\_\_  
New Address: \_\_\_\_\_  
c. \_\_\_ **Other** (please specify): \_\_\_\_\_  
Last Date of Service in the ALF: \_\_\_\_/\_\_\_\_/\_\_\_\_  
New address: \_\_\_\_\_
- \_\_\_ **3. AUXILIARY GRANT ELIGIBILITY TERMINATED** Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Reason: \_\_\_\_\_

<i>(Name of Assessor/Case Manager Completing Form)</i>		<i>(Name of Eligibility Worker Completing Form)</i>	
<i>(Signature of Assessor/Case Manager Completing Form)</i>		<i>(Signature of Eligibility Worker Completing Form)</i>	
<i>(Date)</i>	<i>(Telephone No.)</i>	<i>(Date)</i>	<i>(Telephone No.)</i>

## **ALF ELIGIBILITY COMMUNICATION DOCUMENT INSTRUCTIONS**

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### **WHEN TO USE THIS FORM**

This form is a communication tool between the local department of social services (LDSS) eligibility worker, the assessor/case manager responsible for the 12-month reassessment of the assisted living facility (ALF) resident, and DMAS. This form is completed by:

1. The assessor to the eligibility worker and to DMAS at the time of a 12-month reassessment (a finding that the resident continues to meet either residential or assisted living is required in order for the eligibility worker to redetermine eligibility for an Auxiliary Grant (AG) payment);
  2. Either the assessor or eligibility worker to the other and to DMAS whenever either becomes aware of a change in address; and
  3. The eligibility worker to the ALF assessor and to DMAS whenever the AG is terminated.
- 

### **TO/FROM SECTION**

Both TO/FROM sections must be completed. Completely fill in the locality of the DSS eligibility worker with address and indicate whether document is to be sent to or from the eligibility worker by circling "TO" or "FROM." In the second TO/FROM section, completely fill in the assessor's name, address and provider number and indicate whether the document is to be sent to or from the assessor or case manager by circling "TO" or "FROM."

---

### **RESIDENT IDENTIFICATION SECTION**

1. RESIDENT: Legibly print name of ALF resident who is being assessed, who has moved, or whose AG has been terminated.
  2. SSN: Write in the resident's social security number.
  3. ALF: Legibly print the name of the ALF in which the resident resides.
  4. ALF location: List the city/town in which the ALF is located.
  5. Medicaid Number: Write in the resident's Medicaid number.
- 

**PURPOSE OF COMMUNICATION SECTION:** Check either 1., 2., or 3.

**If 1. is checked** (Annual Reassessment Completed), fill in the date of the reassessment. Check either a. (Resident continues to meet criteria for ALF placement at the following level of care) or b. (Resident does not meet criteria for residential or assisted living. If a. is checked, indicate which level of care the individual meets. If intensive assisted living is checked, respond to the two questions "continues to need intensive assisted living services" and "based on the UAI, continues to meet criteria for intensive assisted living." Usually, both will be checked "yes." When 1. is checked, the assessor sends a copy of the Uniform Assessment Instrument (UAI), the ALF Eligibility Communication Document (ECD), and the CMS-1500 to DMAS. In addition, the assessor sends a copy of the ECD to the LDSS eligibility worker; copies of the UAI and ECD to the ALF; and a decision letter

to the individual being assessed. The assessor should keep a copy of each of these documents.

NOTE: If a reassessment indicates a change in level of care, treat the assessment as a change in level of care. That is, send a copy of the UAI and the DMAS-96 to DMAS. In addition, send the eligibility worker a copy of the DMAS-96; send to the ALF copies of the UAI, DMAS-96, and decision letter; and send a decision letter to the individual being assessed. The assessor should keep a copy of each.

**If 2. is checked** (Resident no longer resides in ALF on record), indicate to where the resident moved (i.e., another ACR, home, or other). For each, indicate the last date of service in the ALF on record. Complete other information such as new address, etc., if known. When 2. is checked, the assessor/case manager or eligibility worker completing the ECD should send a copy to the other and a copy to DMAS and keep a copy for him- or herself.

**If 3. is checked** (Auxiliary Grant Eligibility Terminated), the eligibility worker indicates the effective date of termination and the reason. Then the eligibility worker sends a copy of the ECD to the assessor/case manager and to DMAS.

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### ***SIGNATURES SECTION***

For each form completed, only one signature section will be completed. For example, if an assessor is completing the form for a reassessment, the left-hand side with assessor information will be completed. If the eligibility worker is completing the form for notification of AG eligibility termination, then the right-hand side is completed. Please completely fill in the applicable section with printed name of individual completing the form, signature, complete date with month/day/year, and telephone number with area code.

## UAI/PLAN OF CARE

Client Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Medicaid # \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider ID# \_\_\_\_\_  
Provider Phone # \_\_\_\_\_

Case Management Initiated: \_\_\_\_\_ Medicaid Eligibility Approved: \_\_\_\_\_  
(Date) (Date-if after date initiated)

### MEDICAID CLIENTS ONLY:

Initial Authorization: \_\_\_\_\_ Reauthorization: \_\_\_\_\_  
(Must submit to DMAS prior to billing) Must request 2 weeks prior to end date)

### GOALS: Circle one or more.

1. To assist client to remain in his/her own home/ALF with supports as necessary.
2. To assist client in attaining and maintaining appropriate independent functioning based on his/her capabilities.
3. To assist in arranging out-of-home placements as appropriate with either client/legal representative's consent or court orders.
4. Short-term assistance to access services.
5. Other goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client Name: \_\_\_\_\_  
Social Security # \_\_\_\_\_ Medicaid # \_\_\_\_\_

UNMET NEED FROM UAI SUMMARY	MEASURABLE OBJECTIVE TO MEET IDENTIFIED NEED	TASK(S) TO BE DONE TO MEET OBJECTIVE	EXPECTED TIME FRAME	DATE RESOLVED

UNMET NEED FROM UAI SUMMARY	MEASURABLE OBJECTIVE TO MEET IDENTIFIED NEED	TASK(S) TO BE DONE TO MEET OBJECTIVE	EXPECTED TIME FRAME	DATE RESOLVED

**SIGNATURES:**

\_\_\_\_\_  
**Recipient of Services/Date**
**Case Manager/Date**

**Case Manager Comments:**

**Enrolled by DMAS: Services Effective**\_\_\_\_ **Thru End Date**\_\_\_\_ **DMAS**  
**Analyst**\_\_\_\_\_  
**Date Enrolled**\_\_\_\_\_

## ASSISTED LIVING FACILITY CASE MANAGEMENT SERVICES PROGRESS LOG

RESIDENT NAME: \_\_\_\_\_ MEDICAID ID#: \_\_\_\_\_  
PROVIDER #: \_\_\_\_\_

DATE	ACTION TAKEN	RESULTS OF ACTION TAKEN

CASE MANAGER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## ASSISTED LIVING FACILITY CASE MANAGEMENT PLAN OF CARE INSTRUCTIONS

Care plan means a standardized, written description of the need(s) which cannot be met the assisted living facility (ALF) and the case manager's strategy for arranging services to meet that need(s). Care planning is the core of case management, and it is based on the information gathered during the assessment. The process of care planning includes (1) reviewing the assessment data; (2) using professional knowledge to determine available resources; (3) discussing options with the client, involved informal providers, and the ALF staff; (4) writing the care plan; and (5) explaining and discussing it with the client and applicable caregivers. Specific components of the care plan developed for use with the Uniform Assessment Instrument (UAI) are discussed below.

**Identifying Information:** Record the client's name, social security number, Medicaid number, the name of the provider (the agency where the case manager developing the care plan works), the provider ID number (Medicaid provider # for the case management agency), and the provider phone number. In the next spaces, record the date case management started and the date Medicaid eligibility was approved. Only record the eligibility approval date if it is after the date case management started. Leave this space blank for non-Medicaid clients and/or clients who were Medicaid eligible before the initiation of case management.

**Goals:** These represent overall goals of case management. Circle all that apply. There is also space to write in other goals specific to the client's situation. Goals represent the outcomes of case management and should guide the length of case management services. In other words, when the case manager and client feel these goals have been met, consideration should be given to closing the client's case to ongoing ALF case management services.

**Unmet Need from UAI Summary:** List all of the unmet needs to be addressed in the care plan. These needs should correspond to those identified in the Summary Section of the UAI. The reason for the unmet need should be clear from the UAI.

**Measurable Objective to Meet Identified Need:** A measurable objective is what the client and worker want to achieve for each identified need. These are more specific than the overall goals of case management services. They are written in terms of a client status that is observable or measurable so that the case manager and the client will be able to tell when the outcome has been attained. A common error is listing a service (e.g., home health aide) rather than a client status (e.g., improved functioning as the measurable objective).

Answer the following questions to develop measurable objectives:

1. What is the problem that needs to be solved? For example, you gather the following information from completing the UAI for Mrs. Jones:

Her lower dentures no longer fit; this limits her food intake;  
She has lost 10 pounds in 6 months; and she can't afford to have her dentures fixed.

The problem statement that summarizes this information is that Mrs. Jones is losing weight due to the lack of money to repair her dentures.

2. How will I know if the problem has been solved? The answer to this question should be written in terms of a client status that is observable or measurable so that both parties will be able to tell when the outcome has been attained. Some other questions to ask yourself are: Will the client say or do something differently? Will I be able to observe the client doing something differently? Will the client's environment look different?

## ASSISTED LIVING FACILITY CASE MANAGEMENT PLAN OF CARE INSTRUCTIONS (con't)

From the example above, the measurable objective is: Mrs. Jones will receive new dentures and report eating solid foods regularly. In writing the objective, focus on short-term changes you will be able to see and which will lead to long-term resolution of the problem. In this example, indicate that you will remove the apparent barrier to Mrs. Jones' ability to eat properly (obtain new dentures), and also say that you will observe her eating solid foods (which will then logically lead to improved nutrition).

**Tasks to Be Done to Meet the Objective:** In this column, list the tasks to be done to meet each objective. These are the steps taken to solve the problem. Tasks will often involve obtaining a service for the client. For each service, list the provider and the frequency. Informal as well as formal providers should be included. This may be the section you find easiest to complete. If so, you may want to fill out this section first, and then think about the observable or tangible evidence that will be present to show that the task was accomplished. This would be recorded as the measurable objective (column 2).

**Expected Time Frame:** This is the time frame for accomplishing the measurable objectives.

**Date Resolved:** Record the date the task was accomplished. If the task was not accomplished, make a note of the reason.

**Signatures:** There is space for the client and the case manager to sign the care plan. The client signature is an indication that he or she agrees with the plan.

**Case Manager Comments:** The last section provides space for case manager comments.

**ALF Case Management Services Progress Log:** Case managers shall maintain a record of case management services provided to the ALF clients. The log shall list the dates of all contacts between the case manager and the direct service providers, the ALF staff, and the client. The log should summarize the nature of those contacts and cover services obtained for the client, how the client is responding, what unmet needs remain, and the progress that is being made toward securing still needed services. The log should also identify any changes in the client's social, environmental, and medical circumstances.

**VIRGINIA UNIFORM ASSESSMENT INSTRUMENT ADD-ON PAGE**  
**(for use with the short-form of the UAI--first four pages)**

Individual's Name: \_\_\_\_\_

**DIAGNOSES & MEDICATION PROFILE (Page 5 of UAI)**

**How do you take your medications?**

- \_\_\_\_\_ Without assistance <sup>0</sup>  
\_\_\_\_\_ Administered/monitored by lay person <sup>1</sup>  
\_\_\_\_\_ Administered/monitored by professional nursing staff <sup>2</sup>

**Describe help:**

**Name of helper:**

**BEHAVIOR PATTERN (Page 8 of UAI)**

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) Or become agitated and abusive?

- \_\_\_\_\_ Appropriate <sup>0</sup>  
\_\_\_\_\_ Wandering/Passive - Less than weekly <sup>1</sup>  
\_\_\_\_\_ Wandering/Passive - Weekly or more <sup>2</sup>  
\_\_\_\_\_ Abusive/Aggressive/Disruptive - Less than weekly <sup>3</sup>  
\_\_\_\_\_ Abusive/Aggressive/Disruptive - Weekly or more <sup>4</sup>  
\_\_\_\_\_ Comatose <sup>5</sup>

**Type of inappropriate behavior:**

**Source of information:**

## CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, \_\_\_\_\_, am signing this form for  
(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

\_\_\_\_\_  
(FULL PRINTED NAME OF CLIENT)

\_\_\_\_\_  
(CLIENT'S ADDRESS)

\_\_\_\_\_  
(CLIENT'S BIRTHDATE)

\_\_\_\_\_  
(CLIENT'S SSN – OPTIONAL)

My relationship to the client is: ☐ Self ☐ Parent ☐ Power-of-Attorney ☐ Guardian  
☐ Other Legally Authorized Representative

I want the following confidential information ( except drug or alcohol abuse diagnoses or treatment information) about the client to be exchanged:

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Assessment Information	<input type="checkbox"/>	<input type="checkbox"/>	Medical Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	Educational Records
<input type="checkbox"/>	<input type="checkbox"/>	Financial Information	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Records
<input type="checkbox"/>	<input type="checkbox"/>	Benefits/Services Needed, Planned, and /or Received	<input type="checkbox"/>	<input type="checkbox"/>	Medical Records	<input type="checkbox"/>	<input type="checkbox"/>	Criminal Justice Records
<input type="checkbox"/>	<input type="checkbox"/>	All of the Above	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Records	<input type="checkbox"/>	<input type="checkbox"/>	Employment Records
			<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

I want \_\_\_\_\_  
(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)  
and the following other agencies to be able to exchange this information:

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Nursing Facilities	<input type="checkbox"/>	<input type="checkbox"/>	Area Agencies on Aging	<input type="checkbox"/>	<input type="checkbox"/>	Community Services Board
<input type="checkbox"/>	<input type="checkbox"/>	Home Health Agencies	<input type="checkbox"/>	<input type="checkbox"/>	DMHMESAS	<input type="checkbox"/>	<input type="checkbox"/>	Hospice
<input type="checkbox"/>	<input type="checkbox"/>	Local Health Department	<input type="checkbox"/>	<input type="checkbox"/>	Physicians	<input type="checkbox"/>	<input type="checkbox"/>	Hospitals
<input type="checkbox"/>	<input type="checkbox"/>	Dept. of Medical Assistance	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

**I want this information to be exchanged ONLY for the following purpose(s):**

☐ Service Coordination and Treatment Planning ☐ Eligibility Determination ☐ Other: \_\_\_\_\_

**I want this information to be shared by the following means:** (Check all that apply)

☐ Written Information ☐ In Meetings or By Phone ☐ Computerized Data ☐ Fax Release

I want to share additional information received after this consent is signed: ☐ Yes ☐ No

This consent is good until: ☐ My service case is closed. ☐ Other: \_\_\_\_\_

## CONSENT TO EXCHANGE INFORMATION : SIDE 2

### DECLARATION OF CONSENT

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information. I want all the agencies to accept a copy of this form as a consent to share information.

If I do not sign this form, information will not be shared and I will have to contact each agency individually to give information about me that is needed.

Signature(s): \_\_\_\_\_ Date: \_\_\_\_\_  
(CONSENTING PERSON OR PERSONS)

Person Explaining  
Form: \_\_\_\_\_  
(Name) (Title) (Phone Number)

Witness (If Required): \_\_\_\_\_  
(Signature) (Address) (Phone Number)

Full Printed Name of  
Client: \_\_\_\_\_

### FOR AGENCY USE ONLY

#### CONSENT HAS BEEN:

☐

Revoked in entirety

☐

Partially revoked as follows:

#### NOTIFICATION THAT CONSENT WAS REVOKED WAS BY:

☐

Letter (Attach Copy)

☐

Telephone

☐

In Person

DATE REQUESTED RECEIVED: \_\_\_\_\_

AGENCY REPRESENTATIVE RECEIVING REQUEST:

(AGENCY REPRESENTATIVES FULL NAME AND TITLE)

(AGENCY ADDRESS AND TELEPHONE NUMBER)

**INTERAGENCY CONSENT TO RELEASE CONFIDENTIAL INFORMATION  
FOR ALCOHOL OR DRUG PATIENTS**

I, \_\_\_\_\_, of \_\_\_\_\_  
(Name of patient/client) (Patient/client's address)

authorize \_\_\_\_\_ to disclose to:

\_\_\_\_\_  
(Name, title, and organization to whom disclosure is to be made)

the following information: \_\_\_\_\_  
(Specific information to be disclosed)

for the following purpose(s): \_\_\_\_\_  
(Reason for disclosure)

I understand that my records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for the laws and regulations. I also understand that I may revoke (or cancel) this consent at any time, except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires as described below:

\_\_\_\_\_  
(Date, event, or condition upon which this consent will expire)

I further acknowledge that the information to be released as fully explained to me and that this consent is given of my own free will.

Executed this, the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

This consent ☐ includes ☐ does not include information placed on my records after the above date.

\_\_\_\_\_  
(Signature of patient/client)

\_\_\_\_\_  
(Signature of parent/guardian, where required)

\_\_\_\_\_  
(Signature of person authorized to sign in lieu of parent)

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2.) The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

# MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

## I. RECIPIENT INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Social Security \_\_\_\_\_ Medicaid ID \_\_\_\_\_ Sex: \_\_\_\_\_

## II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible? ☐  
 1 = Yes  
 2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission **OR** within 45 days of application or when personal care begins.  
 3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission

If no, has Individual formally applied for Medicaid? ☐  
 0 = No 1 = Yes

Is Individual currently Auxiliary Grant eligible? ☐  
 0 = No  
 1 = Yes, or has applied for Auxiliary Grant  
 2 = No, but is eligible for General Relief

Dept of Social Services:  
 (Eligibility Responsibility) \_\_\_\_\_

(Services  
 Responsibility) \_\_\_\_\_

## III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ALF screeners)

### MEDICAID AUTHORIZATION

#### Level of Care

- 1 = Nursing Facility Services ☐  
 2 = PACE/LTCHP  
 3 = AIDS/HIV Waiver Services  
 4 = Elderly or Disabled with Consumer Direction Waiver  
 11 = ALF Residential Living  
 12 = ALF Regular Assisted Living  
 14 = Individual/Family Developmental Disabilities Waiver  
 15 = Technology Assisted Waiver  
 16 = Alzheimer's Assisted Living Waiver

NOTE: Authorization for Nursing Facility or the Elderly or Disabled with Consumer Direction Waiver is interchangeable.

Screening updates are not required for individuals to move between services because the alternate institutional placement is the same. Alzheimer's Assisted Living Waiver's alternate institutional placement is a nursing facility, however, the individual must also have a diagnosis of Alzheimer's Or Alzheimer's Related Dementia and meet the nursing facility criteria to qualify.

### NO MEDICAID SERVICES AUTHORIZED

- 8 = Other Services Recommended  
 9 = Active Treatment for MI/MR Condition  
 0 = No other services recommended

### Targeted Case Management for ALF

0 = No 1 = Yes

Assessment Completed

1 = Full Assessment 2 = Short Assessment

ALF provider name: \_\_\_\_\_

ALF provider number: \_\_\_\_\_

ALF admit date: \_\_\_\_\_

### SERVICE AVAILABILITY

- 1 = Client on waiting list for service authorized ☐  
 2 = Desired service provider not available  
 3 = Service provider available, care to start immediately

### LENGTH OF STAY (If approved for Nursing Home)

- 1 = Temporary (less than 3 months) ☐  
 2 = Temporary..(less than 6 months)  
 3 = Continuing (more than 6 months)  
 8 = Not Applicable

### NOTE: Physicians may write progress notes to address

the length of stay for individuals moving between Nursing Facility and the EDCD Waiver. The progress notes should provided to the local departments of social services Eligibility workers.

### LEVEL I/ALF SCREENING IDENTIFICATION

Name of Level I/ALF screener agency and provider number:

1. \_\_\_\_\_

☐☐☐☐☐☐☐☐☐☐

2. \_\_\_\_\_

☐☐☐☐☐☐☐☐☐☐

### LEVEL II OR CSB 101B ASSESSMENT DETERMINATION

Name of Level II OR CSB Screener and ID number who have completed the Level II or 101B for a diagnosis of MI, MR, or RC.

1. \_\_\_\_\_

☐☐☐☐☐☐☐☐☐☐

0 = Not referred for Level II OR 101B assessment

1 = Referred, Active Treatment needed

2 = Referred, Active Treatment not needed

3 = Referred, Active Treatment needed but individual chooses NH

Did the individual expire after the PAS/ALF Screening decision but before services were received? 1 = Yes 0 = No ☐

**SCREENING CERTIFICATION** - This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

Level I/ALF Screener	Title	Date ____/____/____
Level I/ALF Screener	Title	Date ____/____/____
Level I Physician		Date ____/____/____

# Instructions for completing the *Medicaid Funded Long-Term Care Service Authorization Form (DMAS-96)*

1. Enter Individual's Last Name. **Required.**
2. Enter Individual's First Name. **Required.**
3. Enter Individual's Birth Date in MM/DD/CCYY format. **Required.**
4. Enter Individual's Social Security Number. **Required.**
5. Enter Individual's Medicaid ID number if the Individual currently has a Medicaid card. This number should have either nine or twelve digits.
6. Sex: Enter "F" if Individual is Female or "M" if Individual is Male. **Required.**
7. Is Individual Currently Medicaid Eligible? Enter a "1" in the box if the Individual is currently Medicaid Eligible.  
Enter a "2" in the box if the Individual is not currently Medicaid Eligible, but it is anticipated that private funds will be depleted within 180 days after Nursing Home admission or within 45 days of application or when personal care begins.  
Enter a "3" in the box if the Individual is not eligible for Medicaid and it is not anticipated that private funds will be depleted within 180 days after Nursing Home admission
8. If no, has Individual formally applied for Medicaid? Formal application for Medicaid is made when the Individual or a family member has taken the required financial information to the local Eligibility Department and completed forms needed to apply for benefits. The authorization for long-term care can be made regardless of whether the Individual has been determined Medicaid-eligible, but placement may not be available until the provider is assured of the Individual's Medicaid status.
9. Is Individual currently auxiliary grant eligible? Enter appropriate code ("0", "1" or "2") in the box.
10. Dept of Social Services: The Departments of Social Services with service and eligibility responsibility may not always be the same agency. Please indicate, if known, the departments for each in the areas provided.
11. Assessment Type: Enter in the box the number that corresponds to the assessment provided. If this area is not filled in correctly, payment may not be made, may be delayed, or may be incorrect. **Required.**
12. Medicaid Authorization Enter the numeric code that corresponds to the Pre-Admission Screening Level of Care authorized. Enter only one code in this box.

NOTE: Authorization for Nursing Facility or the Elderly or Disabled With Consumer Direction Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same. Alzheimer's Assisted Living Waiver's alternate institutional placement is a nursing facility, however, the individual must also have a diagnosis of Alzheimer's Or Alzheimer's Related Dementia and meet the nursing facility criteria to qualify.

- 1 = **NURSING FACILITY** authorize only if Individual meets the Nursing Facility (NF) criteria and community-based care is not an option.
- 2 = **PACE/LTC PREPAID HEALTH PLAN** authorize only if Individual meets NF criteria (pre-NF criteria does not qualify) and requires a community-based service to prevent institutionalization.
- 3 = **HIV/AIDS WAIVER** authorize only if Individual meets the criteria for AIDS/HIV Waiver services and requires AIDS/HIV Waiver services to prevent institutionalization (that is, case management, private duty nursing, personal/respite care, nutritional supplements).
- 4 = **ELDERLY OR DISABLED WITH CONSUMER DIRECTION WAIVER** authorize only if Individual meets NF criteria and requires a community-based service to prevent institutionalization.
- 11 = **ALF RESIDENTIAL LIVING** authorize only if Individual has dependency in either 1 ADL, 1 IADL or medication administration.
- 12 = **ALF REGULAR ASSISTED LIVING** authorize only if Individual has dependency in either 2 ADLs or behavior.
- 14 = **Individual/Family Developmental Disabilities** authorize only if the Individual meets the criteria for admission into an ICF/MR facility and meets the Level of Functioning screening criteria.
- 15 = **Technology Assisted Waiver** authorize only if the Individual meets the criteria for admission criteria to a NF specialized care level of care and requires a community-based service to prevent institutionalization.
- 16 = **Alzheimer's Assisted Living Waiver** authorization only if the Individual meets the criteria for admission to a NF and requires a community-based service to prevent NF institutionalization. Authorize only if the individual has a medical diagnosis of Alzheimer's Disease. **If ALF is authorized**, enter, if known, in item 29, the provider number of the ALF that will admit the Individual. Enter, in item 27, the date the Individual will be admitted to that ALF.
- 0 = **NO OTHER SERVICES RECOMMENDED** use when the screening team recommends no services or the Individual refuses services.
12. 8 = **OTHER SERVICES RECOMMENDED** includes informal social support systems or any service excluding Medicaid-funded long-term care (such as companion services, meals on wheels, MR waiver, rehab. services, etc.)
- 9 = **ACTIVE TREATMENT FOR MI/MR CONDITION** applies to those Individuals who meet Nursing Facility Level of Care but require active treatment for a condition of mental illness or mental retardation and cannot appropriately receive such treatment in a Nursing Facility.
13. Targeted Case Management for ALF **If ARC, ARR or ARI is authorized**; you must indicate whether Targeted Case Management for ALF (quarterly visits) is also being authorized. The Individual must require coordination of multiple services and the ALF or other support must not be available to assist in the coordination/access of these services. Enter a "0" if only the annual reassessment is required.
14. Service Availability If a Medicaid-funded long-term care service is authorized, indicate whether there is a waiting list (#1) or that there is no available provider (#2), or whether the service can be started immediately (#3).
15. ALF Reassessment: If this is an ALF Reassessment enter the appropriate code for No or Yes. Then mark the appropriate box for a short reassessment or a long reassessment.
16. Length of Stay If approval of Nursing Facility care is made, please indicate how long it is felt that these services will be needed by the Individual. The physician's signature certifies expected length of stay as well as Level of Care.

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility or the EDCD Waiver. The progress notes should provided to the local departments of social services

### Eligibility workers.

17. Level I/ALF Screening Identification Enter the name of the Level I screening & agency or facility (for example, Hospital, local DSS, local Health, Area Agency on Aging, CSB, State MH/MR facility, CIL) and below it, in the 10 boxes provided, that entity's 10 digit NPI number or 9 digit Medicaid number.  
For Medicaid to make prompt payments to Pre-Admission Screening committees, all of the information in this section must be completed. *Failure to complete any part of this section will delay reimbursement.*
19. If the screening is a Nursing Home Pre-Admission Screening completed in the & locality, there should be two Level I screeners, both the local DSS and local Health departments. Otherwise, there will only be one Level I screener identification entered.
20. Do NOT fill in Lines 16 and 17 or lines 18 and 19 if lines 20 and 21 are filled in. Submit a separate DMAS-96 form.
21. Level II Assessment Determination If a Level II assessment was performed (MI, & MR or Dual), enter the name of the assessor on line 20 and the provider number
22. on line 21. Do NOT fill in line 20 and 21 if lines 16 and 17 are also filled in. Submit a separate DMAS-96 form.
23. Enter the appropriate code in the box.
24. When a Screening Committee is aware that an Individual has expired prior to receiving the services authorized by the screening committee, a "1" should be entered in this box.
25. The Level I/ALF Screener must sign and date the form. **Required.**
26. The Level I/ALF Screener must sign and date the form. **Required for all services except ALF placement.**
27. The Level I physician must sign and date the form. **Required for all services except ALF placement. Physician signature and date are the last item to be completed on this form. Physician must sign and date for him/herself; others may not sign/date for the physician.**
28. Enter the date the Individual entered an ALF. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter the date Medicaid Care of the Individual began in this space and place a copy of the form ON TOP of their admission packet.
29. Enter the name of the ALF in which the Individual was placed. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter their name in this space and place a copy of the form ON TOP of their admission packet.
30. Enter the provider number of the ALF in which the Individual was placed. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter their provider number in this space and place a copy of the form ON TOP of their admission packet.

**DMAS-96 Instructions (revised 10/06)**



Client Name:

Client SSN:

## Do you currently use any of the following types of services?

No <sub>0</sub>	Yes <sub>1</sub>	(Check All Services That Apply)	Provider/Frequency:
_____	_____	Adult Day Care	_____
_____	_____	Adult Protective	_____
_____	_____	Case Management	_____
_____	_____	Chore/Companion/Homemaker	_____
_____	_____	Congregate Meals/Senior Center	_____
_____	_____	Financial Management/Counseling	_____
_____	_____	Friendly Visitor/Telephone Reassurance	_____
_____	_____	Habilitation/Supported Employee	_____
_____	_____	Home Delivered Meals	_____
_____	_____	Home Health/Rehabilitation	_____
_____	_____	Home Repairs/Weatherization	_____
_____	_____	Housing	_____
_____	_____	Legal	_____
_____	_____	Mental Health (Inpatient/Outpatient)	_____
_____	_____	Mental Retardation	_____
_____	_____	Personal Care	_____
_____	_____	Respite	_____
_____	_____	Substance Abuse	_____
_____	_____	Transportation	_____
_____	_____	Vocational Rehab/Job Counseling	_____
_____	_____	Other:	_____

## Where are you on the scale for annual (monthly) family income before taxes?

_____	\$20,000 or more ) <sub>0</sub>	(\$1,667 or more ) <sub>0</sub>
_____	\$15,000 - ) <sub>1</sub>	(\$1,250 - \$1,666 ) <sub>1</sub>
_____	\$11,000 - ) <sub>2</sub>	(\$ 917 - \$1,249 ) <sub>2</sub>
_____	\$ 9,500 - ) <sub>3</sub>	(\$ 792 - \$ 916 ) <sub>3</sub>
_____	\$ 7,000 - 9,499 ) <sub>4</sub>	(\$ 583 - \$ 791 ) <sub>4</sub>
_____	\$ 5,500 - 6,999 ) <sub>5</sub>	(\$ 458 - \$ 582 ) <sub>5</sub>
_____	\$ 5,499 or Less ) <sub>6</sub>	(\$ 457 or Less ) <sub>6</sub>
_____	Unknown ) <sub>9</sub>	

## Number in Family

Optional: Total monthly family income: \_\_\_\_\_

## Do you currently receive income from...?

No <sub>0</sub>	Yes <sub>1</sub>	Optional:
_____	_____	Black Lung
_____	_____	Pension
_____	_____	Social Security
_____	_____	SSI/SSDI
_____	_____	VA Benefits
_____	_____	Wages/Salary
_____	_____	Other

## Does anyone cash your check, pay your bills or manage your business?

No <sub>0</sub>	Yes <sub>1</sub>	Names
_____	_____	Legal Guardian
_____	_____	Power of Attorney
_____	_____	Representative
_____	_____	Other

## Do you receive any benefits or entitlements?

No <sub>0</sub>	Yes <sub>1</sub>	
_____	_____	Auxiliary Grant
_____	_____	Food Stamps
_____	_____	Fuel Assistance
_____	_____	General Relief
_____	_____	State and Local Hospitalization
_____	_____	Subsidized Housing
_____	_____	Tax Relief

## What types of health insurance do you have?

No <sub>0</sub>	Yes <sub>1</sub>	
_____	_____	Medicare, #
_____	_____	Medicaid, #
_____	_____	Pending: No <sub>0</sub> Yes <sub>1</sub>
_____	_____	QMB/SLMB No <sub>0</sub> Yes <sub>1</sub>
_____	_____	:
_____	_____	All Other
_____	_____	Public/Private:

Client Name:

Client SSN:

**Where do you usually live? Does anyone live with you?**

	Alone <sub>1</sub>	Spouse <sub>2</sub>	Other <sub>3</sub>	Names of Persons in Household	
___ House: Own <sub>0</sub>					
___ House: Rent <sub>1</sub>					
___ House: Other <sub>2</sub>					
___ Apartment <sub>3</sub>					
___ Rented Room <sub>4</sub>					
	Name of Provider (Place)			Admission Date	Provider Number (If Applicable)
___ Adult Care Residence <sub>50</sub>					
___ Adult Foster <sub>60</sub>					
___ Nursing Facility <sub>70</sub>					
___ Mental Health/Retardation Facility <sub>80</sub>					
___ Other <sub>90</sub>					

**Where you usually live are there any problems?**

No <sub>0</sub>	Yes <sub>1</sub>	(Check All Problems That Apply)	Describe Problems:
___	___	Barriers to Access	
___	___	Electric Hazards	
___	___	Fire Hazards/No Smoke Alarm	
___	___	Insufficient Heat/Air Conditioning	
___	___	Insufficient Hot Water/Water	
___	___	Lack of/Poor Toilet Facilities	
___	___	(Inside/Outside)	
___	___	Lack of/Defective Stove, Refrigerator, Freezer	
___	___	Lack of/Defective Washer/Dryer	
___	___	Lack of/Poor Bathing Facilities	
___	___	Structural Problems	
___	___	Telephone Not Accessible	
___	___	Unsafe Neighborhood	
___	___	Unsafe/Poor Lighting	
___	___	Unsanitary Conditions	
___	___	Other: _____	

Client Name:

Client SSN:



## FUNCTIONAL STATUS (Check only one block for each level of functioning.)

ADLS	Needs Help?	
	No <sub>00</sub>	Yes
Bathing		
Dressing		
Toileting		
Transferring		
Eating/Feeding		

MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3 D		Performed by Others 40			Is Not Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
					Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	

Continence	Needs Help?	
	No <sub>00</sub>	Yes
Bowel		
Bladder		

Incontinent Less than Weekly 1	Ext. Device/ Indwelling/ Ostomy Self Care 2	Incontinent D Weekly or More 3	External Device Not Self Care 4	Indwelling D Catheter Not Self Care 5	Ostomy D Not Self Care 6

Ambulation	Needs Help?	
	No <sub>00</sub>	Yes
Walking		
Wheeling		
Stairclimbing		
Mobility		

MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3 D		Performed D by Others 40	Is Not Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
					Confined Moves About	Confined Does Not Move About

IADLS	Needs Help?	
	No <sub>0</sub>	Yes <sub>1</sub>
Meal Preparation		
Housekeeping		
Laundry		
Money Mgmt.		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

### Outcome: Is this a short assessment?

 \_\_\_\_\_ No, Continue with Section 3  
 (0)

 \_\_\_\_\_ Yes, Service Referrals  
 (1)

 \_\_\_\_\_ Yes, No Service Referrals  
 (2)

Screener: \_\_\_\_\_

Agency: \_\_\_\_\_

Client Name:

Client SSN:



## PHYSICAL HEALTH ASSESSMENT

Doctor's Name(s) (List all)	Phone	Date of Last Visit	Reason for Last Visit

**Admission: In the past 12 months have you been admitted to a ... for medical or rehabilitation reasons?**

No <sub>0</sub>	Yes <sub>1</sub>		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

**Do you have any advance directives such as... (Who has it...Where is it...)?**

No <sub>0</sub> Yes <sub>1</sub>

Location

\_\_\_\_\_ Living Will, \_\_\_\_\_  
 \_\_\_\_\_ Durable Power of Attorney for Health \_\_\_\_\_  
 \_\_\_\_\_ Care, \_\_\_\_\_  
 \_\_\_\_\_ Other, \_\_\_\_\_

**Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as ... (Refer to the list of diagnoses)?**

**Current Diagnoses**

**Date of Onset**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Diagnoses:  
 Alcoholism/Substance Abuse (01)  
 Blood-Related Problems (02)  
 Cancer (03)  
 Cardiovascular Problems  
   Circulation (04)  
   Heart Trouble (05)  
   High Blood Pressure (06)  
   Other Cardiovascular Problems (07)  
 Dementia  
   Alzheimer's (08)  
   Non-Alzheimer's (09)  
 Developmental Disabilities  
   Mental Retardation (10)  
   Related Conditions  
     Autism (11)  
     Cerebral Palsy (12)  
     Epilepsy (13)  
     Friedreich's Ataxia (14)  
     Multiple Sclerosis (15)  
     Muscular Dystrophy (16)  
     Spina Bifida (17)  
 Digestive/Liver/Gall Bladder (18)  
 Endocrine (Gland) Problems  
   Diabetes (19)  
   Other Endocrine Problem (20)  
 Eye Disorders (21)  
 Immune System Disorders (22)  
 Muscular/Skeletal  
   Arthritis/Rheumatoid Arthritis (23)  
   Osteoporosis (24)  
   Other Muscular/Skeletal Problems (25)  
 Neurological Problems  
   Brain Trauma/Injury (26)  
   Spinal Cord Injury (27)  
   Stroke (28)  
   Other Neurological Problems (29)  
 Psychiatric Problems  
   Anxiety Disorder (30)  
   Bipolar (31)  
   Major Depression (32)  
   Personality Disorder (33)  
   Schizophrenia (34)  
   Other Psychiatric Problems (35)  
 Respiratory Problems  
   Black Lung (36)  
   COPD (37)  
   Pneumonia (38)  
   Other Respiratory Problems (39)  
 Urinary/Reproductive Problems  
   Renal Failure (40)  
   Other Urinary/Reproductive (41)  
 All Other Problems (42)

Enter Codes for 3 Major, Active Diagnoses:

None <sub>0</sub>

DX1

DX2

DX3

**Current Medications Dose, Frequency, Route Reason(s) Prescribed**

(Include Over-the-Counter)

1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_  
 4. \_\_\_\_\_  
 5. \_\_\_\_\_  
 6. \_\_\_\_\_  
 7. \_\_\_\_\_  
 8. \_\_\_\_\_  
 9. \_\_\_\_\_  
 10. \_\_\_\_\_

**Total No. of Medications:**

(If 0, skip to Sensory Function)

**Total No. of Tranquilizer/Psychotropic Drugs:**

**Do you have any problems with medicine(s)...? How do you take your medications?**

No <sub>0</sub> Yes <sub>1</sub>

\_\_\_\_\_ Without assistance 0  
 \_\_\_\_\_ Administered/monitored by lay person 1  
 \_\_\_\_\_ Administered/monitored by professional nursing staff 2  
 Describe help: \_\_\_\_\_  
 Name of helper: \_\_\_\_\_  
 Understanding directions/schedule

Client Name:

Client SSN:

**How is your vision, hearing, and speech?**

	No Impairment <sub>0</sub>	Impairment <i>Record Date of Onset/Type of Impairment</i>		Complete Loss <sub>3</sub>	Date of Last Exam
		Compensation <sub>1</sub>	No Compensation <sub>2</sub>		
Vision					
Hearing					
Speech					

**Joint Motion: How is your ability to move your arms, fingers, and legs?**

\_\_\_\_\_ Within normal limits or instability corrected <sub>0</sub>

\_\_\_\_\_ Limited motion <sub>1</sub>

\_\_\_\_\_ Instability uncorrected or immobile <sub>2</sub>

**Have you ever broken or dislocated any bones ... Ever had an amputation or lost any limbs ... Lost voluntary movement of any part of your body?**

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
_____ None 000	_____ None 000	_____ None 000
_____ Hip Fracture 1	_____ Finger(s)/Toe(s) 1	_____ Partial 1
_____ Other Broken Bone(s) 2	_____ Arm(s) 2	_____ Total 2
_____ Dislocation(s) 3	_____ Leg(s) 3	Describe _____
_____ Combination 4	_____ Combination 4	
_____ <b>Previous Rehab Program?</b>	_____ <b>Previous Rehab Program?</b>	_____ <b>Previous Rehab Program?</b>
_____ No/Not Completed 1	_____ No/Not Completed 1	_____ No/Not Completed 1
_____ Yes 2	_____ Yes 2	_____ Yes 2
_____ <b>Date of Fracture/Dislocation?</b>	_____ <b>Date of Amputation?</b>	_____ <b>Onset of Paralysis?</b>
_____ 1 Year or Less 1	_____ 1 Year or Less 1	_____ 1 Year or Less 1
_____ More than 1 Year 2	_____ More than 1 Year 2	_____ More than 1 Year 2

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Recent Weight Gain/Loss: \_\_\_\_\_ No <sub>0</sub> \_\_\_\_\_ Yes <sub>1</sub>

(Inches) (lbs.) Describe: \_\_\_\_\_

**Are you on any special diet(s) for medical reasons?**

\_\_\_\_\_ None 0

\_\_\_\_\_ Low Fat/Cholesterol 1

\_\_\_\_\_ No/Low Salt 2

\_\_\_\_\_ No/Low Sugar 3

\_\_\_\_\_ Combination/Other 4

**Do you take dietary supplements?**

\_\_\_\_\_ None 0

\_\_\_\_\_ Occasionally 1

\_\_\_\_\_ Daily, Not Primary Source 2

\_\_\_\_\_ Daily, Primary Source 3

\_\_\_\_\_ Daily, Sole Source 4

**Do you have any problems that make it hard to eat?**

No <sub>0</sub> Yes <sub>1</sub>

\_\_\_\_\_ Food Allergies

\_\_\_\_\_ Inadequate Food/Fluid Intake

\_\_\_\_\_ Nausea/Vomiting/Diarrhea

\_\_\_\_\_ Problems Eating Certain Foods

\_\_\_\_\_ Problems Following Special Diets

\_\_\_\_\_ Problems Swallowing

\_\_\_\_\_ Taste Problems

\_\_\_\_\_ Tooth or Mouth Problems

\_\_\_\_\_ Other \_\_\_\_\_

Client Name:

Client SSN:

**Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as...?**

No <sub>0</sub>	Yes <sub>1</sub>	Frequency
_____	_____	Occupational _____
_____	_____	Physical _____
_____	_____	Reality/Remotivation _____
_____	_____	Respirator _____
_____	_____	Speech _____
_____	_____	Other _____
_____	_____	_____

**Special Medical Procedures: Do you receive any special nursing care, such as ...?**

No <sub>0</sub>	Yes <sub>1</sub>	Site, Type, Frequency
_____	_____	Bowel/Bladder Training _____
_____	_____	Dialysis _____
_____	_____	Dressing/Wound Care _____
_____	_____	Eye care _____
_____	_____	Glucose/Blood Sugar _____
_____	_____	Injections/IV Therapy _____
_____	_____	Oxygen _____
_____	_____	Radiation/Chemotherapy _____
_____	_____	Restraints (Physical/Chemical) _____
_____	_____	ROM Exercise _____
_____	_____	Trach Care/Suctioning _____
_____	_____	Ventilator _____
_____	_____	Other: _____

**Do you have pressure ulcers?**

None <sub>0</sub>	Location/Size
_____	Stage I 1 _____
_____	Stage II 2 _____
_____	Stage III 3 _____
_____	Stage IV 4 _____

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

**Are there ongoing medical/nursing** \_\_\_\_\_ No <sub>0</sub> \_\_\_\_\_ Yes <sub>1</sub>

**If yes, describe ongoing medical/nursing needs:**

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

**Comments:**

Optional: Physician's  
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Other  
s: \_\_\_\_\_

Date: \_\_\_\_\_

(Signature/Title)



## PSYCHO-SOCIAL ASSESSMENT

### Orientation *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

**Person:** Please tell me your full name (so that I can make sure our record is correct).

**Place:** Where are we now (*state, county, town, street/route number, street name/box number*)? Give the client 1

*point for each correct response.*

**Time:** Would you tell me the date today (*year, season, date, day, month*)?

Oriented 0

**Spheres**

Disoriented – Some spheres, some of the time 1

Disoriented – Some spheres, all the time 2

Disoriented – All spheres, some of the time 3

Disoriented – All spheres, all of the time 4

Comatose 5

### Recall/Memory/Judgment

**Recall:** I am going to say three words. And I want you to repeat them after I am done ( House, Bus, Dog). \*

**trial. \*** Ask the client to repeat them. Give the client 1 point for each correct response on the first

mind Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his

because you will ask him again in a minute or so what they are.

**Attention/**

**Concentration:** Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).

**Short-Term:** \* Ask the client to recall the 3 words he was to remember.

**Long-Term:** When were you born ( What is your date of birth)?

**Judgment:** If you needed help at night, what would you do?

No 0 Yes 1

Short-Term Memory Loss?

Long-Term Memory Loss?

Judgment Problems?

Optional: MMSE Score

(5)

(5)

(3)

(5)

Total:

**Note:** Score of 14 or below implies cognitive impairment.

### Does the client ever wander without purpose (trespass, get lost, go into traffic, etc...) or become agitated and abusive?

Appropriate 0

Wandering/Passive – Less than weekly 1

Wandering/Passive – Weekly or more 2

Abusive/Aggressive/Disruptive – Less than weekly 3

Abusive/Aggressive/Disruptive – Weekly or more 4

Comatose 5

Type of inappropriate behavior: \_\_\_\_\_

Source of Information: \_\_\_\_\_

### Are there any stressful events that currently affect your life, such as ...?

No 0 Yes 1

Change in

Death of someone close

Family conflict

No 0 Yes 1

Financial problems

Major illness- family/friend

Recent move/relocation

No 0 Yes 1

Victim of a crime

Failing health

Other \_\_\_\_\_

Client Name:

Client SSN:

In the past month, how often did you ...?	Rarely/ Never <sub>0</sub>	Some of the Time <sub>1</sub>	Often <sub>2</sub>	Most of the Time <sub>3</sub>	Unable to Assess <sub>9</sub>
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you don't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living ... or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite ... that is, eat too much or too little?					

Comments:

### Are there some things that you do that you especially enjoy?

No <sub>0</sub>      Yes <sub>1</sub>

Describe

_____	_____	Solitary Activities,	_____
_____	_____	With Friends/Family,	_____
_____	_____	With Groups/Clubs,	_____
_____	_____	Religious Activities,	_____

### How often do you talk with your children family or friends either during a visit or over the phone?

Children  
n

Other Family

Friends/  
Neighbors

_____ No Children 0	_____ No Other Family 0	_____ No Friends/Neighbors 0
_____ Daily 1	_____ Daily 1	_____ Daily 1
_____ Weekly 2	_____ Weekly 2	_____ Weekly 2
_____ Monthly 3	_____ Monthly 3	_____ Monthly 3
_____ Less than Monthly 4	_____ Less than Monthly 4	_____ Less than Monthly 4
_____ Never 5	_____ Never 5	_____ Never 5

### Are you satisfied with how often you see or hear from your children other family and/or friends?

\_\_\_\_\_ No 0

\_\_\_\_\_ Yes 1

Client Name:

Client SSN:

**Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves emotional/mental health alcohol or substance abuse problems?**

No <sub>0</sub>

Yes <sub>1</sub>

Name of Place	Admit Date	Length of stay/Reason

**Do (did) you ever drink alcoholic beverages?**

Never 0

At one time, but no longer <sub>1</sub>

Currently 2

How much: \_\_\_\_\_

How often: \_\_\_\_\_

**Do (did) you ever use non-prescription, mood altering substances?**

Never 0

At one time, but no longer <sub>1</sub>

Currently 2

How much: \_\_\_\_\_

How often: \_\_\_\_\_

*If the client has never used alcohol or other non-prescription, mood altering substances, skip to the tobacco question.*

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?	Do (did) you ever use alcohol/other mood-altering substances with ...	Do (did) you ever use alcohol/other mood-altering substances to help you ...
<p>No <sub>0</sub>      Yes <sub>1</sub></p> <p><b>Describe concerns:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>No <sub>0</sub>      Yes <sub>1</sub></p> <p>_____ Prescription drugs?</p> <p>_____ OTC medicine?</p> <p>_____ Other substances?</p> <p><b>Describe what and how often:</b></p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>No <sub>0</sub>      Yes <sub>1</sub></p> <p>_____ Sleep?</p> <p>_____ Relax?</p> <p>_____ Get more energy?</p> <p>_____ Relieve worries?</p> <p>_____ Relieve physical pain?</p> <p><b>Describe what and how often:</b></p> <p>_____</p> <p>_____</p> <p>_____</p>

**Do (did) you ever smoke or use tobacco products?**

Never 0

At one time, but no longer <sub>1</sub>

Currently 2

How much: \_\_\_\_\_

How often: \_\_\_\_\_

**Is there anything we have not talked about that you would like to discuss?**

Client Name:

Client SSN:



## Assessment Summary

**Indicators of Adult Abuse and Neglect:** While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1-55.3, to report this to the Department of Social Services, Adult Protective Services.

### Does the client have an informal caregiver?

\_\_\_\_ No <sub>0</sub> (Skip to Section on Preferences)

\_\_\_\_ Yes <sub>1</sub>

### Where does the caregiver live?

\_\_\_\_ With client <sub>0</sub>

\_\_\_\_ Separate residence, close proximity <sub>1</sub>

\_\_\_\_ Separate residence, over 1 hour away <sub>2</sub>

### Is the caregiver's help ...

\_\_\_\_ Adequate to meet the client's needs? <sub>0</sub>

\_\_\_\_ Not adequate to meet the client's needs? <sub>1</sub>

### Has providing care to client become a burden for the caregiver?

\_\_\_\_ Not at all <sub>0</sub>

\_\_\_\_ Somewhat <sub>1</sub>

\_\_\_\_ Very much <sub>2</sub>

### Describe any problems with continued caregiving:

Client's preference for receiving needed \_\_\_\_\_

Family/Representative's preference for client's \_\_\_\_\_

Physician's comments (if applicable): \_\_\_\_\_

Client Name:

Client SSN:

### Unmet Needs

No <sub>0</sub> Yes <sub>1</sub> (Check All That Apply)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Finances  
Home/Physical Environment  
ADLS  
IADLS

No <sub>0</sub> Yes <sub>1</sub> (Check All That Apply)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Assistive Devices/Medical Equipment  
Medical Care/Health  
Nutrition  
Cognitive/Emotional  
Caregiver Support

### Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider #	Section(s) Completed

Optional: Case  
assigned to:

Code #: